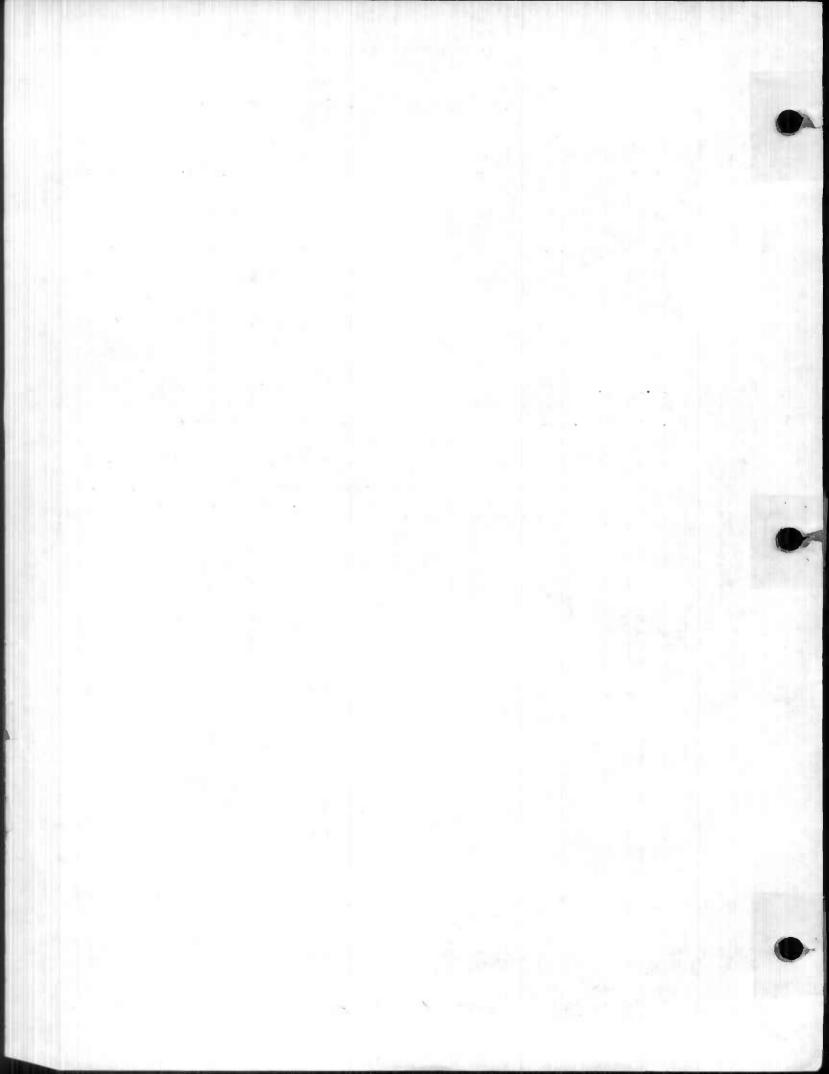
emend i		23a,	,27 per m	ne G788 10 e (First, Middle,	)/23/00 yi		Antho	Certifica		f Death	2. Date of D Month	Da	y	Year	2900   3. Time of Death
	dical	40 E	acitity Name //	If not institution,			Allelio	117	01111		SEPTEM r Location of Dea			2000 of Death	10:57 A
Exam	niner		BAYVIE	W HOSP	ITAL					BALTIMO	RE		. County	1	N/A
Funera Directo		2	218-08-9 al Residence of	9864	5. Sex 1⊠ M 2□ F	7. Age (In )		(rs. Month	der 1 Yee			rth Pay, Year) 21,19	70	9. Birthple Counti Mary	ce (State or Foreign y) land
the Meryland 28e-f ahow nouthed at	tor	10a.	State	10b. County	Baltimor		City, Town	or Location		Edgemere				10	d. Inside City Limits
23a or 28	al Director		Street and Nur 7431 BJ	mber levins <i>F</i>	venue		54	10f.	Zip Code	21219				What Counti	
Herna Merna	by Funeral	1	Meritel Status  Never Marri  Widowed	led 21 Marrie	d 1 Tye	ecedent Ever in Forces?  Is 2 No Give  r Dates:	n U,S.	If Yes, s	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.)  1□ Yes 2☒ No Specify:  1□ Yes 2☒ No Specify:			ck, Whita, at			
Man y failed within 72 hours af de 2 should be filled within 72 hours af the and Mental Hygiener fran "ratural", or traumetic event, an Medical Examitration	Completed	Fis	(Spec	15. Decedent's	grade complete	ed)	16a.	Decedant's U (Give kind of life. DO NO?	work don	e during most of w	orking	16b. K	(ind of Bu	usiness/Indu	ustry
W 12 L 10	Com	Lie	12 Yea		College	3 (1-401 5+)		Wire Drawer					Ste	eel In	ndustry
be filed that Hygin d other event,	Be		7. Father's Name (First, Middle, Last) William J. Shifflett					18. Mother's Name (First, Middle, M						1a)	
should ind Men	2	-				/572 E - \					cicia An				
12 sh h and r le m raum				ame/Relationshi		(Wife)						al Route Number, City or Town, State, Zip Coda)  Edgemere, Maryland 21219			
s 1 en of Heal hem 2		20a.	Method of Disp	position	Mrs. Rebecca L. Shifflett  7431 Blevins Avenue Edgemere, Maryland 21219  20a. Method of Disposition  20b. Place of Disposition (Nama of cemetery, Crematory or other place)  20c. Location - City or Town, State										
Pa Intra		1 100	Oak Lawn Cemetery 9/15/2000 Baltimore, MD												
1 2 2 2 2		-	-		ecity)			awn Cei	mete:	ry 9/15/	2000		alti	more,	MD
Pemit. Page Copartment of Copa		21. S 23a	Pant Enter france	he disease, or or a failure. List or	censee complications that	auca at ceused the d n each lina.	Oak L	awn Cel 22. Name Duda 7922 of antar tha m	mete: and Add -Ruc! Wis		Home of	Ba f Dur Mary	ndal:	k, Ind	
Physicia /Medica Examine	ıl er	21.5 23a Imm dised resu	Part Enter the hock head ediata Causa (ese or condition liting in death)	he disease, or cirt failure. List or	censee complications that	at ceused the den each lina.	Oak L  Oak L  Oak L  Oak L	awn Cel 22. Name Duda 7922 of antar tha m	mete: and Add —Ruc: Wise node of d	ry 9/15/ ress of Facility k Funeral e Ave. I	Home of	Ba f Dur Mary	ndal:	k, Ind	C • 2 2 2 Approximate Interval Between
Physician / Medica Examine physician and physician and se as the burial-transit	edical Examiner	21. S 23a Immidiserresu Sequifant ceus Caus that	Pant Entarti shock near	he disease, or cirt failure. List or Final n	censee complications that	at ceused the done ach lina.	Oak L  Cleath Don  RHYTHMI  O (or as a c	awn Cel 22. Name Duda: 7922 or antar tha m	mete: and Add —Ruc: Wisc mode of d	ry 9/15/ ress of Facility k Funeral e Ave. I	Home of	Ba f Dur Mary	ndal:	k, Ind	C • 2 2 2 Approximate Interval Between
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aw requires that the death certificate be executed  State of the attending physician and a should be detached for use as the burial-transit	by Physician/Medical Examiner	23a Imm diserresu Sequif any coust that resul	Part Enter had been also be dista Causa (ese or condition liting in death) uentially list cory, leading to imple. Enter Under the company of the condition of t	he disease, or or n failure. List or fai	b	at ceused the don each lina.	Oak I.  RHYTHMI o (or as a co	awn Cel 22. Name Duda: 7922 ot antar tha m  A onsequence of	mete: and Add —Ruc; Wisc onode of d  of):	ry 9/15, ress of Facility k Funera: e Ave. I	L Home ODundalk, ac or respiratory	Bat Dur Mary arrast.	o uae co	k, Ind d 21:	222 Approximate nterval Between Onset and Death Onset and Death  the cause of death' ably 4 Unknow re autopsy findings liable prior to spletion of ceuse asth?
be law requires that the death certificate be executed that been signed by the attending physician and ge 2 should be detached for use as the burial-transit	Completed by Physician/Medical Examiner	23a Imm diserresu Sequit if an oceus Caus that resul	Part Enter Indiana dediata Causa (asse or condition liting in death)  uentially list cory, leading to imite. Enter Undese (bisassa or initiated evants titing in death) I.  Under significant of the condition liting in death) I.  Under significant condition liting in death) I.	ne disease, or cirt failure. List or (Final no meditions, mediata triying injury Last	b	at ceused the don each lina.	Oak I.  RHYTHMI o (or as a co	awn Cel 22. Name Duda: 7922 ot antar tha m  A onsequence of	mete: and Add —Ruc; Wisc onode of d  of):	ry 9/15, ress of Facility k Funeral e Ave. I ying, such as card	L Home ODundalk, ac or respiratory	Bar Dur Mary Mary arrast.	ndal.	k, Ind d 21:	2 2 2 Approximate Interval Between Onset and Death  the cause of death' ably 4 Unknown Italian Prior to pletion of ceuse
clan: The law requires that the death certificate be executed entificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial-transit	o Be Completed by Physician/Medical Examiner	21. \$ 23a Immm diserresu Sequifi annous Caus that resul	Part Entante and ediata Causa (ese or condition liting in death)  uentially list cory, leading to imite. Enter Unde (Disease or Initiated evants Iting in death) I.  Under elgniff	ne disease, or or failure. List or failu	b  considering to the contributing to	Due to death but not	Oak I.  Beath. Dorn  RHYTHM  O (or as a coop (or as a coop resulting in	awn Cel 22. Name Duda: 7922 ot antar than A onsequence of the underlyin	mete: and Add Ruc: Wisconde of di of):  of):	ry 9/15/ ress of Facility k Funera. e Ave. I ying, such as card	23b. Dic	f Dur Mary arrast.  f tobacco Yee 2 san autoformed?  Yes 2 ona)	o use co	ntribute to 3 Prob	Approximate interval Between Onset and Death Onset O
be law requires that the death certificate be executed that been signed by the attending physician and ge 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical Examiner	Imm diserresu  Sequifiant Causthat resul  Pert I  25. V 9 1	Part Entante and ediata Causa (ese or condition liting in death)  uentially list cory, leading to imite. Enter Unde (Disease or Initiated evants Iting in death) I.  Under elgniff	ne disease, or or failure. List or failu	b. CAF  CAF  b. C.	Due to death but not	Oak I.  RHYTHMI o (or as a co o (or as a co resulting in	awn Cel 22. Name Duda: 7922 ot antar than A onsequence of the underlyin	mete: and Add Ruc; Wisconde of delivery of the control of the cont	ry 9/15/ ress of Facility k Funeral e Ave. I givan in Part I.	L Home ODundalk, ac or respiratory	f Dur Mary arrast.  f tobacco Yee 2 s an auto formed?  Yes 2 ona) sidence	o use co	ntribute to 3 Probi	Approximate interval Between Onset and Death Onset O

29c. License number 29d. Data signed (Month, Day, Year) O.C.M.E SEPTEMBER 11,2000

of person who complated cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

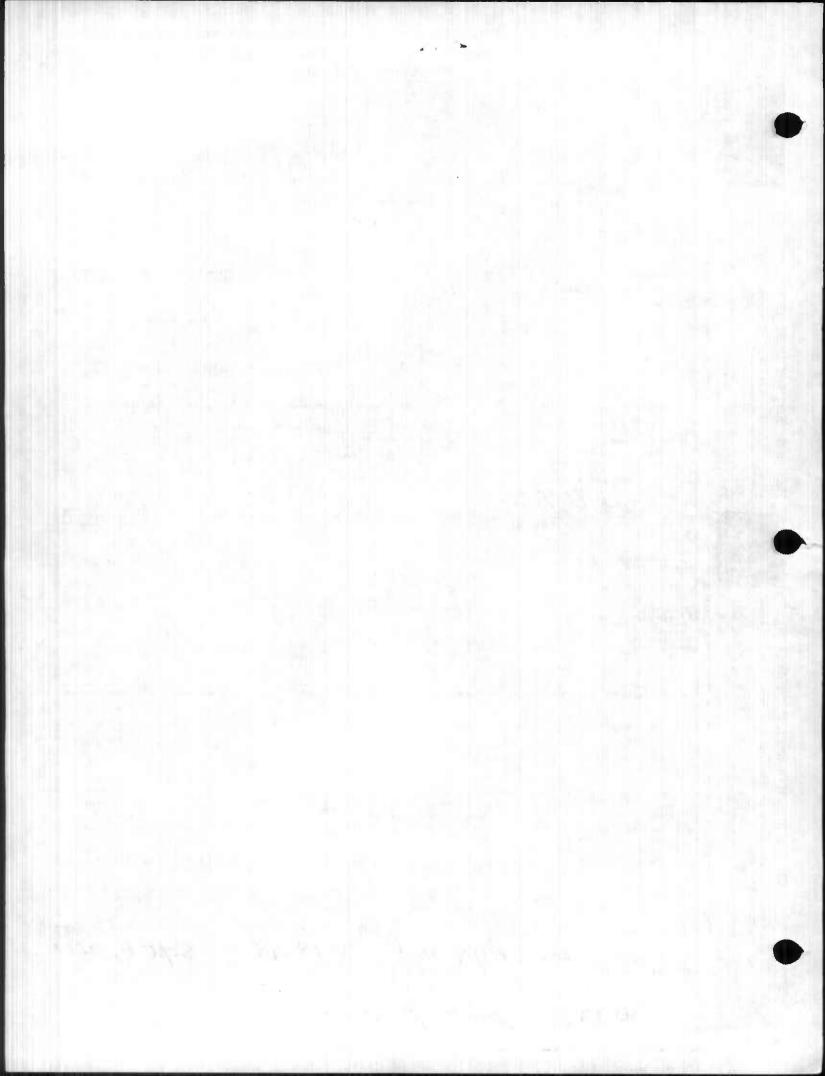
State Registrar



State of Maryland / Department of Health and Mental Hygiene 00 29002

	Cert	ificate of Death	Re	g. No.						
Physician /Medical	1. Decedent's Nama (First, Middle, Last) FREDERICK W. SMITH	',	2. Date of Death Month September	Day Year	3. Tima ot Death 6:20 am					
/Medical Examiner	4a Facility Name (If not institution, give street and number) VA Medical Center Fort Howard		, or Location of Death	4c. County of Deet	th					
Funeral Director	5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 213-32-9645 7. M 2 F 63 Yrs.	Fort H 		Baltimor	e thpiace (State or Foreign ountry) y land					
28a-f show multilad at rector	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Local MD . BAL	ation TIMORE			10d. Inside City Limits					
0 B D	10e. Street and Number	10f. Zip Code	10	og. Citizen of What Co	puntry?					
than "natural", or items 23 for Medical Examiner must probleted by Funeral	1 Never Married 2 Married 1 1 Married 2 No 3 / 3 0	es Decedent of Hispanic Orlgin Yes, specify Cuben, Mexican, P	7 (Specify Yes or No- Puerto Rican, atc.)	No- 14. Reca - American Indian, Bleck, White, etc.						
- B	3 Widowed 4 Divorced Year or Dates: 12/37	☐ Yes #☐ No Specify:	1	Specify: 1	BLACK					
Ngiene. Ner than *naturi nt, try medical Completed	Elamentary/Secondary (0-12)   College (1-4or 5+)	nt's Usual Occupation ind of work done during most of O NOT use retired) NTENANCE		INTEGRA HEALTH SI						
atic event,	17. Father's Neme (First, Middle, Last)  ROBERT SMITH	18. Mothar's	Name (First, Middle, M PICOLAR	faiden Sumame) SMITH						
a 27 is ma	GERALDINE SMITH 2866	Address (Street and Number of W. BALTO. S	T. BALTIN	MORE, MD.	. 21223					
nent of He ant: If Nen ury or oth	20a. Method of Disposition  1 #Buriai 2 Cramation 3 Removal from Stata 4 Donetion 5 Other (Specify)	ition (Name of atory or other place) N FOREST		OC. Location - City or OWINGS	Town, State MILLS MD					
Departmen important: any Injury pncs.	21. Signature of Funeral Servica Licensee 22.	Neme end Address of Facility ESTEP BROTH 1300 EUTAW	IERS FUNER	RAL HOME	P.A.					
ysician	23e. Pert1. Enfer the disease, or complications that caused the death. Do not entail shock, or heart tailure. List only one cause on each fine.				Approximata Intervat Between Onsat and Death					
Medical kaminer		a								
s the burial-transit	b	Celebro Vascular Accident  b. Due to (or as e consequence ot):								
E .	Sequentially tist conditions, if any, tasding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting In death) Last  Due to (or as e consequence to	ence ot):								
ed by the attending detached for use as	Pert II. Other significant conditions contributing to death but not resulting in the unc	derlying ceuse given in Part t.			to the cause of death					
58 5			24a. Wes ar		Were autopsy tindings evailable prior to complation of cause					
page 2			1 □ Ye	s 200 No	of déath? 1 ☐ Yes 2 ☐ No					
this certificate ral director, pag	25. Was cesa reterred to medical axeminer?  1 Yes 25 No Hospitat 1 Inpatient 2 ER/Outpatient	3□ DOA Other: 4□ Nursi	Death (Check only one ing Homa 5 Rasida	ince 6 Other (Spe	scify)					
leath. for: After the fune	27. Manner ot Death 1 XINatural 2 Accident 3 Suicide 4 Homicida 28. Date ot Injury (Month, Day Year) 28b. Time of injury 2b. Ti	28c. Injury at Work?  M 1 Yes 2 No		ow Injury occurred  reat and Number or R  7, Stata)	tural Route Number,					
within 24 hours after of the transfer of the funeral Direct completely filled in by Medical Certifi	29a. Certifier  (Check only one)  29 Medical Examiner: On the best of my knowledge, death of the best of my knowledge, death of the basis of examination and/or investigation.									
Within Comple	29b. Signatura and titla of cartifiar  Augustin China. m. &	29c. License number 7-182		9d. Date signed (Mon Seft. 6	th, Day, Year)					
	30. Neme and address & parson who completed ceusa of death (Item 23a) (Type, P Augustin Chyu, M.D. 9600 North Point R		rd, Marylar	nd 21052						
State Registrar	SEP 1 3 2000 32. Registrer's Signeture	Sparks								

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth September 8, 2000 **Physician** Mary Henrietta Seaman 1:00 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Chesapeake Hospice Home Linthicum Anne Arundel If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 XX Yrs. 4/8/1915 85 Maryland Director 220-18-3974 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 156 Maryland Avenue 21122 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Yes AN No if Yes, Give Year or Dates: 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: Specify: White by 3 K/Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filled within 7 Department of Heelih and Mental Hygiene. Important: if item 27 is marked other than "nu any injury or other traumatic event, the Mental page. Elementery/Secondery (0-12) Coilege (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Wesley Ritter Emilyetta Aiken 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mary O'Connor - Daughter 156 Maryland Avenue, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 9/11 Crownsvile Veteran Cem. 4 Donation 5 Other (Specify) Crownsville, MD 21. Signeture of Funeral School Licensee 22. Name end Address of Fecility FINK FUNERAL HOME, PA 426 Crain Hwy., SW, Glen Burnie, MD 21061 Kelly Gregory Fink 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset end Deeth **Physician** immediate Cause (Final disease or condition resulting in deeth) /Medical Alzheimer's Disease 2 Years **Examiner** Due to (or as a consequence of): Physician/Medical Examiner Atherosclerotic Cardiovascular Disease The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue Due to (or as e consequence of): Box 68760. the Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Osteoarthritis Division of Vital Records. þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed Recurrent Urosepsis 90ed 1 Yes 2 XX 1 Yes 2 No or Attending Physician: 25. Was case referred to medicel exeminer? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence Cother (Specify) hospice 1 Yes 2000 Certification: To 28a. Dete of injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of home 1XXXX urai 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) yd ni bellii 4 Homicide To the Hospital within 24 hours of To the Funeral Completely filled Hospital \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 8.5000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 795 Aquahart Road, Glen Burnie, MD 21061 Edward Sherman, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95

Registrar

SEP 1 3 2000

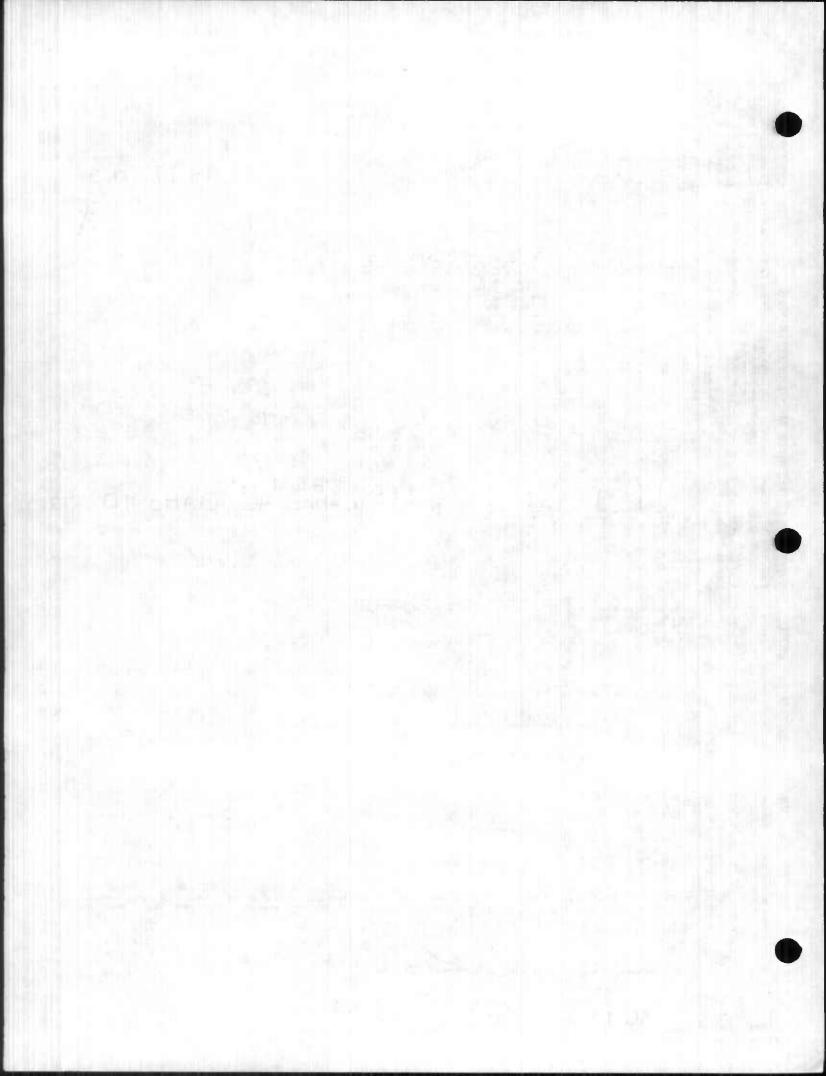
Dengano

Amen	ded Item#2 DED ITEM #	29d perPHYG788 10/10/2000 State of Maryland / De 17 PER FH G787 9/13/00 AH	epartment of H Certificate of L	lealth and M Death	lental Hygi	ene g. No.	0 29004			
	Physician	Flinora M Sewell			2. Data of Death Month Septemb	Dav	3. Tima of Deeth 2000 10:08A			
	/Medical Examiner	4e Facility Neme (If not institution, give street and number)	4	b. City, Town, or Lo		4c. County				
	,	Good Samaritan Hospital		Baltimo			N/A			
1	Funeral Director	5. Sociel Security Number 2836 6. Sax 1 M 2 M F 7. Age (In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day, Feb 8	Year) 905	9. Birthplece (State or Foreign Country) Maryland			
	2 3	Usual Residence of Decedent  10a. Stete 10b. County 10c. City, Town of	or Location				10d. Inside City Limits			
	28a-f shown nutified at					1 □ Yes				
	with the Maryland a or 28a-f show the notified at	10e. Street and Number	10f. Zip Code	TOUR CO.	10	g. Citizan of V	What Country?			
	me 23a o	1518 Dellsway Rd.	212			USA				
	nours after ceam with the Mai urat, or frame 23a or 28a-f a a Examiner must be notified d by Funeral Director		13. Wes Decedent of H If Yes, specify Cuba  1 ☐ Yas 2 ☒ No		ecity Yes or No- Rican, etc.)	Bled	ca - American Indian, ck, White, etc. y: White			
	nn /2	15. Decedent's Education (Specify only highest grade complated)  Elementery/Secondery (0-12)  College (1-4or 5+)	16a. Decedent's Usuel Occupation (Give kind of work done during most of work) life. DO NOT use retired)				usiness/Industry			
Maryland 2	De veri	17. Father's Neme (First, Middle, Last)	TREETER	18. Mother's Neme	(First, Middle, N		ne)			
IZ.	marked marked		Vailing Address (Street							
1.1	27 is 27 is or trau		18 Dellsw							
Baltimore,	Pages 1 and nent of Health int: If hem 27 iny or other ti	cemetery,	Disposition (Name of cremetory or other place with Cemete	ery 9/	Dete 2		City or Town, Steta			
Balt	Departmen Important: any injury poce.	21. Signeture of Funeral Service Licensee J - gair	22. Name and Address Ruck Tow 1050 Yor	son Fun	eral Ho	ome, I	inc. 21204			
	Physician /Medical	23a. Part . Either the diseasa or complications that caused the death. Do no sheck, of heart failure. Lat only one cause of each line.	t enter the mode of dyin	g, such as cardiec	or respiratory arre	est,	Approximete Interval Between Onset and Death			
	Examiner	disease or condition resulting in deeth)  Due to (or as a consequence of):								
	physician and the burishtransit dical Examiner	Cause (Disease or injury that initiated events Dua to (or es e cor	/	70000			y and			
.O. Box	ne law requires that the death certificate rate has been signed by the attending physipage 2 should be detached for use as the Completed by Physician/Medic	d Part II. Other algorificant conditions contributing to death but not resulting in the	the underlying cause giv	en in Pert i.	23b. Did to		ontributs to the cause of death?			
ords	as been signed in 2 should be defined by P	recurrent 117	T	9	24a. Wes ei perform	n autopsy ned?	24b. Were autopsy tindings available prior to completion of cause of death?			
Re	ate has page 2				1 □ Ye	s 2 No	1 ☐ Yes 2 ☐ No -			
/ita	yactan: Ing is certificate director, pag To Be Co	25. Wes case reterred to medical		26. Place of Deet	h (Check only on	9)				
of	F Sign	1 ☐ Yes 2 No Hospitel: 1 ☐ Inpatient 2 DER/Outp		4 U Nursing Ho	me 5 Reside					
uo .	After fune	1 Naturel 5 Pending (Month, Dey Year) Inju	ury Wor	k? Yes 2 □ No	200. 2000120 110	w mjary cooo.				
Divisi	tal or Attanding Pris after death.  al Director: After led in by the funeral Certification:	3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, ferm building, etc. (Specify)	n, street, factory, office		28f. Location (St. City or Town		ber or Rural Route Number,			
	Funer fely fill	29e. Certiflier (Check only one)  1 Certifying Physician: To the best of my knowledge, of the control of the best of my knowledge, o								
	To the comple		29c. Licens	e number ) 15414	2	9d. Date signe	ed (Month, Day, Year)			
	9	30. Name and address of passan and completed cause of death (Itam 23a) (T)	alt mae	MD	Vu 1	VGU	YEN, no			
	State Registrar	31. Date filed (Month, Dey, Year) SEP 1 3 2000 32. Registrer's Signature	& spons	6						

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 00 29005

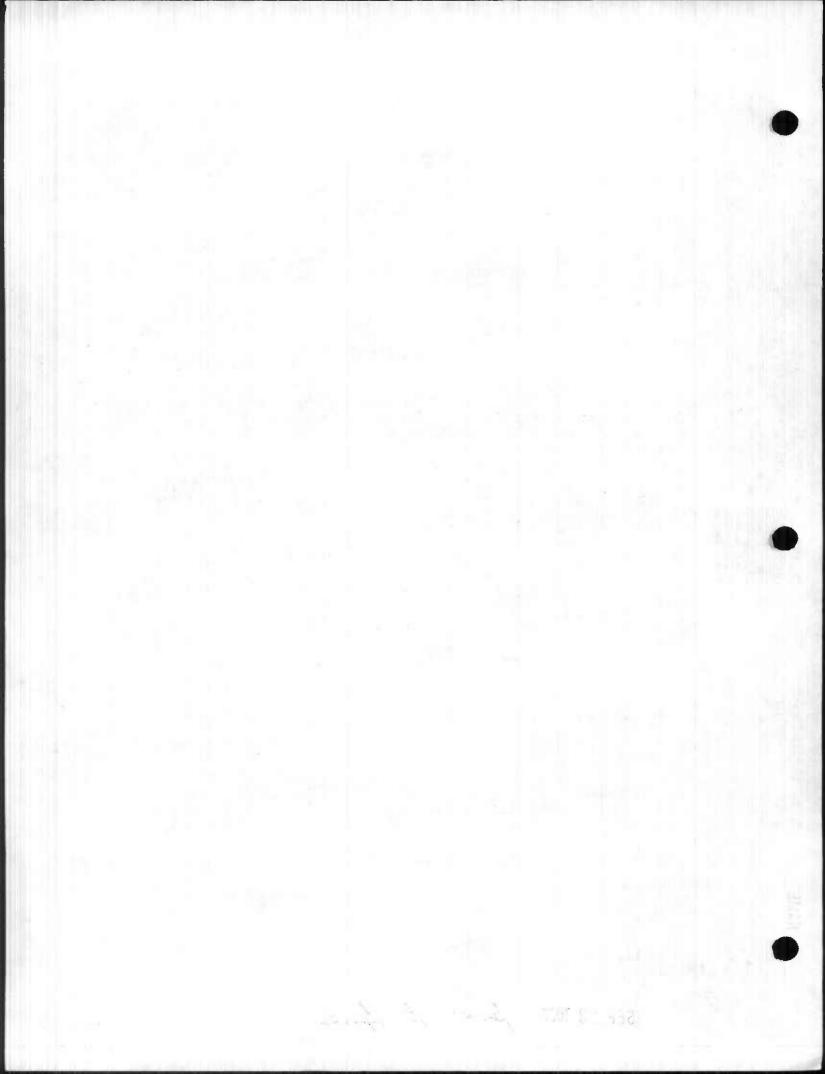
				Certificate of De	ath	Reg. No.	2000
Physi	oion	1. Decedent's Name (First, Middle, Last		Those	2	. Dete of Death Month Day Y	3. Time of Death
/Med		TOA	MAT	VAVE		AUG 31,20	60 /-
Exam	iner	4a Facility Name (If hot institution, give	street and number)	4b. C	ity, Town, or Loca	tion of Death 4d. 96unty of	Deeth
Funera Directo		5. Social Security Number 6. Se 2 2 7 8 0 11  Usuel Residence of Decedent	77. Age (In yrs. las		Under 24 Hrs. 8 lours Min.	De E Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
Maryland of ahow	tor	10a. Stele 10b. County	10c. City,	Town or Location (LAC)	71481	28	10d. Inside City Limits 100 Yes 2 □ No
fier death with the Manylar ritems 23s or 28s-f show ther man be motified at	ai Director	10e. Street and Number 3517 WHT	TE CHAPET	aRD 10f. Zip Code	215	10g. Citizen of Wha	it Country?
-0020 hours effer death with the Manyland hurst', or flerne 23a or 28a-f ahow	by Funeral	11. Marriel Stetus  Diorer Married 2 Married  Widowed 4 Divorced	12. Wes Decedent Ever in U,S. Armed Forces?  1 Yes 2 No If Yes, Give/ Yeer or Detes:	13. Was Decedent of Hisparif Yes, specify Cuban, M	nic Origin? (Speci fexican, Puerto Ri pecity:		American Indian, White, etc.
21215- ad within 72 rgiene. or than "ner t, tre team	Completed	15. Decedent's Edu (Specify only highest grad	College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done durin life. DO NOT use retiged)	GWA	LER A	ess/Industry
Maryiand 2 42 should be filed h and Mentel Hygi 7 is marked other traumatic event, it	To Be (	17. Father's Name (First, Middle, Last)	ENKINS	18.	Mother's Name (	First, Middle, Maiden Sumame) 051E JE	THYTH
nore, land and of Health it: If Hem 2: y or other		19a. Informant's Name/Relationship (7)  20e. Method of Disposition  Postal 2 Cremation 3 II Constion 5 Other (Specify,	Removal from State 20b. Placen	19b. Mailing Address (Street and 357) ce of Disposition (Name of refery, crematory of other place)	2 WHITE	Tolus 20c. Location - City	FUT MO ZIED
Baitim permit. Pa Departmen important: any injury	Miled	21. Signature of Funeral Service Liberal	-	32. Name and Address of HARCH HARCH	Ficility of 9/	5/00	MD 21215
		23a. Furti. Enter the disease, or comp	lications that caused the deeth.	Do not enter the mode of dying, so	uch as cardiac or i	respiretory errest,	Approximate Interval Between
Physician /Medica Examine	r	Immediate Cause (Final disease or condition resulting in death)	. My	O CAPD JAC as a consequence of):	IN	FARATI &	Onset and Death
60, be axecuted icien and burial-transit	Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause, Obisease or injury	b Due to (or a	as a consequence of):			
687 lificate ig phys as the	Medical	resulting in death) Last		s a consequence of):			
P.O. Box that the death cert ed by the attending detached for use	Physician		d				
the de	ysic	Part II. Other significant conditions co	ntributing to death but not result	ing In the underlying cause given in	Part I.		ibute to the cause of death?
S, P. es that the	/ Ph	NBD	OM THAT	HORT	1C.	1 ☐ Yes 2 ☐ No 3	Probably
COTOS requires been sign should be	Completed by		HAEUR	YSM		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
The law ste has page 2	E O					1□Yes No	1 Yes 2 No
ysicien: The ysicien: The director, pag	Bec	25. Was case referred to medical examiner?		26	. Place of Death (	Check only one)	
on of ing Phys After this funeral d	2	1 Pes 2 No  27. Manner of Death Anatural 5 Pending investigation		8b. Time of 28c. Injury et Work?		e 5 Residence 6 Other id. Describe how injury occurred	
Division of or Attending s after death. I Director: Afte od in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Placa of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, office	28	f. Location (Street and Number City or Town, Stete)	or Rural Route Number,
DIVIS To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	edicai			edge, deeth occurred at the time, on and/or investigetion, in my opinion			
To the To the comple	×	29b. Signeture end title of certifier	NA	29c. License nu	CO 5	76 29d. Date signed (	Monthly Day, Year)
de		30. Name and eddress of person who e		GRAXTO H.	3100	Towanda Ave	21215 Baltimore Md
S Regis	tate trar	SFP 1 3 2000	32. Registrar's Signatu	" Sparks			



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29006

	Certificate of Death	Reg. No.
	Decedent's Name (First, Middle, Last)	2. Dete of Deeth 3. Time of Death
Physician /Medical	William Aloysius Thielemann	Sept 12 200 03:00
Examiner	4a Facility Name (It not institution, give street end number) St. Agnes KealthCare  8altim	r Location of Death 4c. County of Deeth N/A
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 100 M 2 F 84 Yrs. 1 Hours Mit	
9 8	Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Mary Med a for	Maryland Baltimore Catonsville	1 ☐ Yes 2 💢 No
a or 28a-f show the notified at I Director		10g. Citizen of What Country?
Uze of them 23s Examiner must by Funeral	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  1 Never Merried 2 Married  1 Pes 2 No If Yes, specify Cuban, Mexican, Pue If Yes, Specify Cuban, Mexican, Pue 1 Pes 2 No If Yes 2 No If Yes 2 No If Yes 2 No Specify:	
5-0 72 ho 72 ho 72 ho	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupetion (Give kind of work done during most of w	16b. Kind of Business/Industry
1 21215-0020 ed within 72 hours at yogiene. or then "natural", or it, the Medical Exam Completed by I	(Specify only highest grade completed)  Elamentary/Secondary (0-12)  12  (Give kind of work done during most of wiffle. DO NOT use retired)  Roman Catholic Price	
Be C	17. Father's Name (First, Middle, Last)	ame (First, Middle, Maiden Sumeme)
yla ould b Ments arked arked To 8		Margaret Eckrich
, Mar and 2 sh aith and 27 is m or traum	19a. Informant's Name/Relationship (Type, Print) Associated Sulpicians of the U.S.  19b. Malling Address (Street end Number or F	Rural Routa Number, City or Town, Stata, Zip Code) Baltimore, MD 21210
More, Pages 1.1 set of the mit if item ry or other ry	20a. Mathod of Disposition  1	Data 20c. Location - City or Town, Steta 9-16-00 Baltimore, Maryland
Departm Departm Importa any inju		altimore, Maryland 21214
box 68/60, death certificate be executed death certificate be executed a strending physician and death or use as the burial-transit siclar/Medical Examiner	Immediate Causa (Final disease or condition resulting in death)  a. Congestive Heart failure  Due to (or as a consequence of):  Exacerbation of chronic obstrue  Due to (or as a consequence of):  Chronic Renal failure  Chronic Renal failure  Due to (or es a consequence of):  Chronic Renal failure  Due to (or es a consequence of):  Status post-aortic valve rep	
death cer death cer death cer death cer	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death
Phys Phys	Hyperteusion	1 Yes 2 No 3 Probably Munknow
Physician: The law requires that this centificate has been signed trail director, page 2 should be detiral CTO Be Completed by P.: To Be Completed by P.		24a. Was an autopsy performed?  24b. Wera autopsy findings available prior to completion of cause of death?
victor: The licent The licentificate hirector, page	25. Was case raterred to medicat 26. Place of D	1□Yes 2♥No 1□Yes 2♥No
Physician: The Interpretation of the Interpr	examinar?	eath (Check only one)  Home 5 Residence 6 Other (Specify)
ding Physical distributions of the Total distrib	27. Manner of Death  1. Panding  28a. Date of Injury (Month, Dey Year)  28b. Tima of Injury at Work?	28d. Dascribe how Injury occurred
bal or Attending P is after death.  al Director: After ied in by the funeric Certification:	2 Accident Investigation M 1 1 Yes 2 No 3 Suicide 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	281. Location (Street end Number or Rurel Route Number, City or Town, Stete)
To the Hospital of within 24 hours at To the Funeral D completely filled in Medical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowladge, death occurred at the time, data and place (Check only one)  1 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred and mannar stated.	ce, end dua to tha causa(s) and manner as stated. curred at tha tima, data and place, and dua to the cause(s)
Nithin Fo the comple	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
	I Leila Kump, M.D. P14444	9/12/00
OB	30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print)  LEILA KUMP ST. AGNCS HOSPIT.	AL
State Registrar	31. Data filed (Month, Dey, Year)  SEP 1 3 2000  A Local Line Company A	

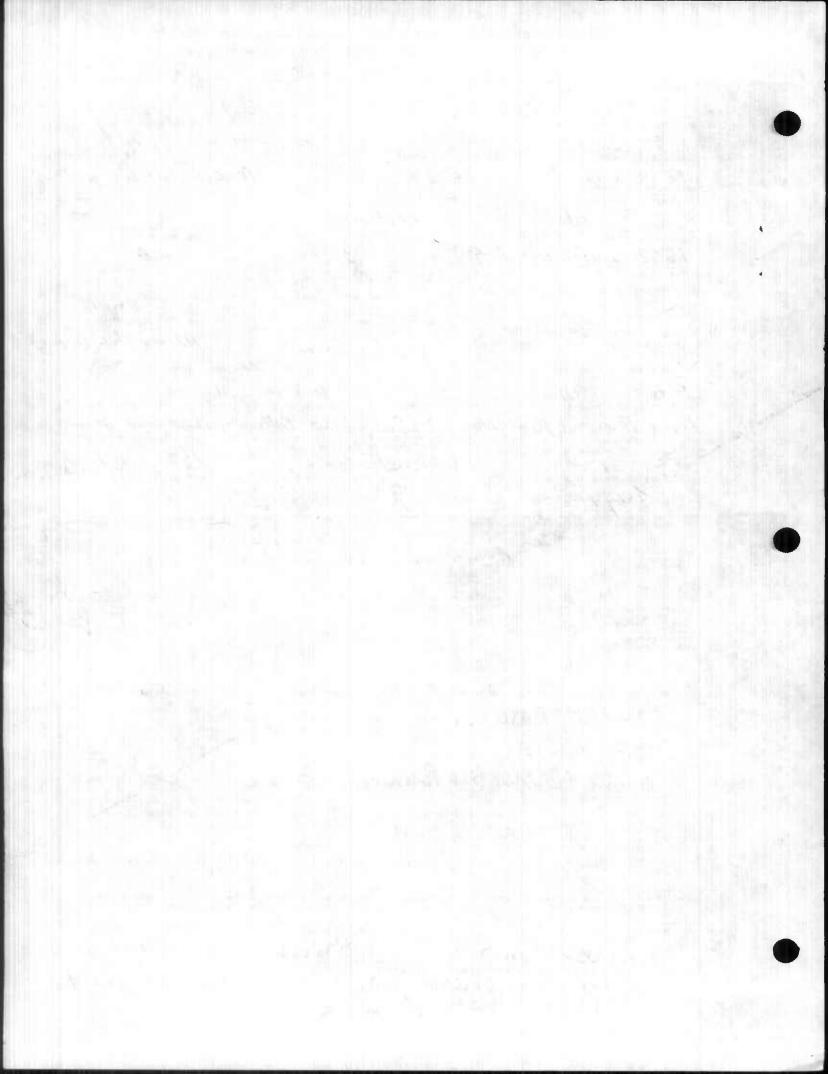
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State of Maryland / Department of Health and Mental Hygiene

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				Certificate of	Death	Reg	. No.	
	Physician	1. Decedent's Nama (First, Middla, Last)	,			2. Dala of Death Month	Day Yaar	3. Time of Death
$\bar{q}_{i}\Pi$	/Medical	Walter Ea	nl	THOMPS	4b. City, Town, or Lo	SEpt.	5 2000	
	Examiner	4a Facility Name (If not institution, give street a 1658 Cliftview	) Aut		BALL	i more		10
	uneral rector	5. Social Security Number 6. Sex 2/2 / O 2/26 Usual Rasidence of Decedant	7. Aga (In yrs. last b	virthday) If Under 1 Yaer Months Days	If Under 24 Hrs. Hours Min.	8. Dala of Birth Month, Dey, Y Mak. 2	9. 1914 O	thplace (State or Foreign puntry)
Maryland	and show iffed at	10a. State 10b. County Maryha N/A	10c. City, To	wn or Location BALTIMORE				10d. Inside City Limits
6 8	at be notified	100. Street and Number 1658 CLIPTUIEW	Ars	101. Zip Coda	213	100	Citizen of What Co	ountry?
020 rrs after dys	traminer must examiner must by Funeral	11. Meritel Statue 12. We Am 1 Never Married 2 Merried 11. We fit Y	s Decedent Ever in U,S. ned Forcas? I Yas 22 No as, Giva er or Detes:	13. Was Decedent of Pilit Yes, specify Cub	en, Maxican, Puerto	ecity Yes or No- Rican, atc.)	14. Reca - Ame Black, Whit Specify;	a, etc.
1215-0020	t, the Medical is Completed	A 40	leted)	a. Decedent's Usual Occup (Give kind of work dona life. DO NOT use retire STEEL WORL	during most of works d)	ina	b. Kind of Business/	Andustry Grapmey
land 2	ked other to be event, th o Be Co	17. Father's Name (First, Middle, Last) ROBERT THOMPSON		STEEL WOR		(First, Middle, Ma		
nore, Mary	or other traumet	19a. Informant's Name/Relationship (Type, Prince 19a) 19a. Information (Type, Prince 19a) 19a. Informa	righte 3.	Db. Meiling Addrass (Street  13 Guyur)  13 Guyur)  15 of Disposition Nama of ary, cramatory or other pie	and Number or Run	Al Route Number, C		21229
Baltim permit. Pa	Important: any injury otics	4 Donallon 5 Other (Specify)  21. Signature of Funeral Service Utensee	weste	22. Name and Addres 5240 RE BALLMON		MANAN-	Atensui Me, HARRIS	s Funeral Hono
/M	sician edical miner	23a. Part i. Enter the disease, or complications shock, or heart feilura. List only one ceus immediate Cause (Finel disease or condition rasulting in deeth)	My o ca	o not anter the mode of dyl	farch	or respiratory arres	i,	Approximele Interval Between Onset and Deeth
x 68760, entificate be executed	ding physician and se as the burial-transit	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events rasulting in death) Lest		e consequence of):				
Geath c	C 3	Day II Other design			in Boat	225 Didash		to the cause of death?
P. of the	4	Pert II. Other eignificant conditions contributing	g to death but not resulting	in the underlying cause gr	van in Part I.			a to the cause of death?  robably 4 Unknown
Records,	page 2 should be def	Hypertenseo	n o	) <sub>1</sub>		24a. Was an performe		Were autopsy findings available prior to completion of cause of death?
	certificate has rector, page 2 Be Comp	Chromic Olist.  25. Was case referred to medical	ructive Pi	Minonemy	Di Sas	l 1□ Yas		1 Yas 2 No
of Vita Physician:	T di	axaminer? 1 Yes No Hospital	1 Inpatient 2 ERV	Julpatient 3LJ DOA	har: 4 Nursing Ho	ma 5 Pesiden 28d. Describe how	ca 6 Other (Spe	ecify)
Division of Vital To the Hospital or Attending Physician: T within 24 hours after death.	on on	Natural   5   Pending	(Month, Dey Year)		ny at nk? ] Yas 2 No		eet end Number or A	lural Routa Number,
Hospital 24 hours	To the Funeral Direct completely filled in by Medical Certifi	29a. Certifier 1 Certifying Physician: (Check only one) 2 Medical Examiner: Or an						
To the	To the compi	29b. Signeture end title of certifier	M. ).		se number 35 08 2	290	d. Date signed (Mon	th, Day, Year)
	NO	30. Name and address of person who complete  S. RAWESH 233	d cause of death (Item 23a 3 QRULAN	) (Type, Print)	BALT	I MORE	m) 2	1004
	State	31. Data tiled (MS/Eh/Pay1 Y3r) 7000	32. Registrar's Signatura	D Ason	6			



ADH RONALD M. VICKERS 00-5119-005

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

29008

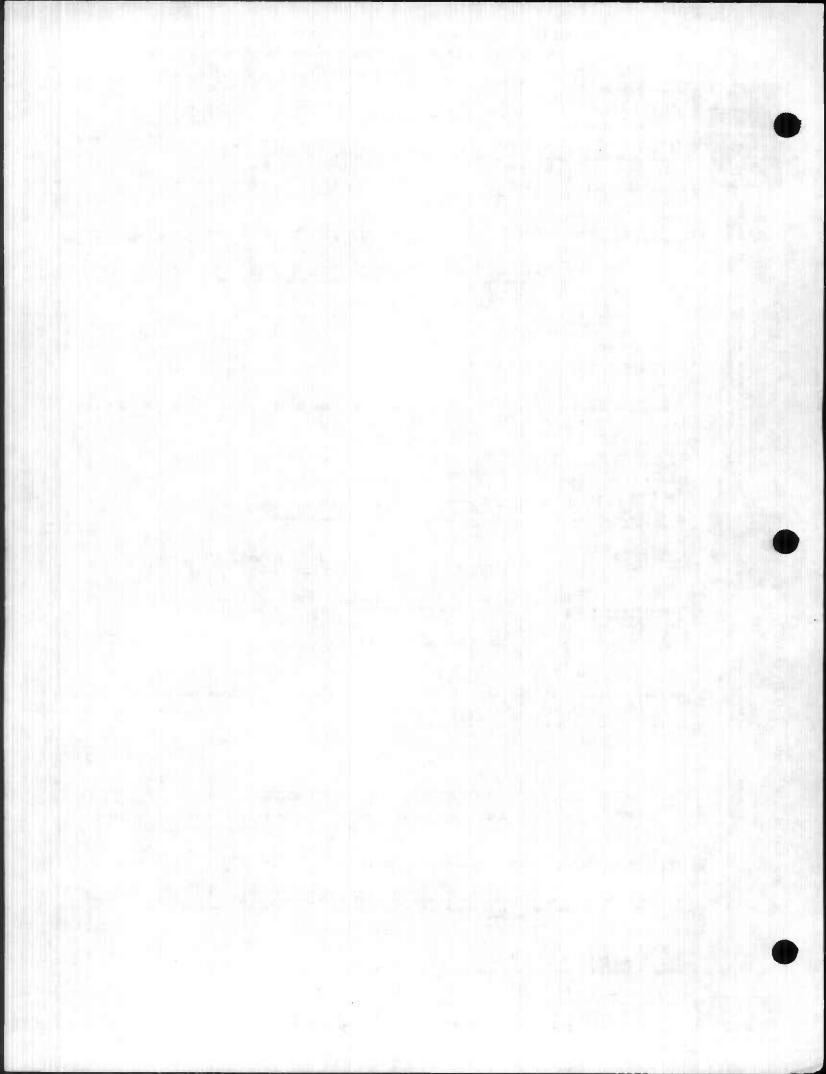
						Cert	inicale of	Dealii		Reg. No.		
Physic			ama (First, Middla M. Vicke						2. Date of D Month SEPTEM	Day	3. Tima of 1 2000 2118 I	
/Medi Exami				give street and number,	)			4b. City, Town, or				
**				D AVENUE		4. 4. 1	If Under 1 Year	DUNDALK  If Under 24 Hrs	0 Date -1 D	BALTIMORE		
Funeral Director		5. Social Securit 214-82-	3023	6. Sex 7. A	ga (In yrs. last bir 50	Yrs.	Months Days		8. Date of B (Month, D) 04/30	50 Year)	Birthplace (State or Country)     MD	
and		Usual Residence	e of Decedent 10b. County		10c. City, Tow	n or Loc	ation				10d. Inside Cit	
ter death with the Menylan Herne 23s or 28e-f ehow	0	MD	Baltim	ore	Baltim	ore				101		
the the	Director	10a. Street and			34202	10f. Zip Code				10g. Citizen of What Country?		
3a or		2507 Mc	Comis Av	enue		21222						
death me 2	Funerai	11. Marital Statu	IS	12. Was Decedent							ce - American Indian,	
6 6	by Fu		larried 2 Marri	Armed Forces' ed 1 7 Yas 2 1 If 7 es, Give 1 Yaar or Datas:			Yes, specify Cub		to Prican, etc.)	Specif	ck, White, etc.  Y: Caucasian	
n 72 hours "natural",			15. Decedent	's Education	16a.	Decede	ent's Usual Occup	pation	al-in-a	16b. Kind of B	usiness/Industry	
within 72 ene. then "net	Completed		econdary (0-12)	t grada completed) College (1-4or	5+)	life. D	O NOT usa retire	during most of wo	rking			
DOL	COL	12	, (-		M	lecha	anic			DA	P	
2 2 2 3	To Be (		ne (First, Middle, I Vickers	ast)				18. Mother's Nat		e, <i>Maid</i> en Su <i>m</i> er ek	ne)	
S DE E	-	19a. Informant's	s Name/Relationsh	nip (Type, Print)	19b	. Mailing	Address (Street	t end Number or Ri	ural Route Num	ber, City or Town	, State, Zip Code)	
475	Important: if tem 27 any injury or other tr	Mrs. Ch	ristina	Bowings	79	06 T	ansdale	Road. Ba	altimore	MD 21	224	
		20a. Method of	Disposition		20b. Place o	Dispos	sition (Neme of latory or other ple		Date		- City or Town, State	
Peges nert of I int: If Its			on 5 Other (Sp	3 ☐Removal from State pecify)	Oak La	5.773			0/13/00	Palti	more, MD	
Departm Importa any inju		21. Signature of	Funeral Service I	icensee	Sour Da		Name and Addre	is of Facility Tal	Home.	P A	INTEY I'D	
20E 28		) C	0000	Racion	owski	120	01 Dunda	lk Avenue	Balti	more. M	21222	
		23a. Part1. Ent	er the disease, or	complications that cause only one cause on each	d the death. Do				-		Approximate Interval Betv	
/Medical Examiner  bhysician and sthe butal-transit	Examiner	Immediate Cau diseasa or conc resulting in dea  Sequentially list if any, leeding t cause. Enter U Cause (Disease that initiated ev	dition th)	a. Hypener	Due to (or as a	consequ	uence of):	adionscu	AC DIS	PASE		
nding use a	n/Medical	Cause (Disease that initiated ev resulting in dear	or Injury ents th) Last	d	Due to (or as a	consequ	uence of):					
the death y the atter	sicia	Part II. Other sig	gnificant conditio	ns contributing to death	but not resulting i	n the un	derlying ceuse gi	iven in Part I.	23b. Di	ontributs to the cause of		
	by Physicia					not resulting in the underlying couse given in Part i.			1 Yes 2 No 3		-/	
law requires that as been signed b	Completed b									is an autopsy formed?	24b. Were autopsy fi available prior to completion of co of death?	
0 - 2	mo:								15	Lyes 2□No	1) Yes 20	
	Be		eferred to medical					26. Place of De	ath (Check only	one)		
0 0	To	examiner? Yes 2	2□ No	Hospital: 1 Inpat	iant 2 ER/O	utpatient	1 3□ DOA Ot	ther: 4 Nursing I	Homa 5□Re	sidence 6 QOt	her (Specify) AT S	
Attending Ph r death. ector: After th by the funeral		27. Manner of D 1. Natural 2 Acciden	5 Pendin		ury ey Year) 28b.	Time of Injury	M 1 [	ryat ork? ]Yes 2 ☐ No	28d. Describe	e how injury occu	rred	
d or Atte after de Directo d in by th	Certification:	3 ☐ Sulcide 4 ☐ Homici		ned 200. Place of it	njury - At home, fa dc. (Specify)	arm, stre	et, factory, office			(Street and Num own, State)	ber or Rural Route Num	
To the Hospital or A within 24 hours affer To the Funeral Dire completely filled in b	edicai C	29a. Certifier (Check only one)		Physician: To the best examiner: On the basis of and manner s	of examination an							
vithin To the comple	Me		and title of certifier	- marrior a			29c. Licen	se number		29d. Date sign	ed (Month, Day, Year)	
H 3 H 0	14	•		INM M	1		O	OME	1	SEPTEMBI	ER 10, 2000	
1/5	11	00.11-	. 7	111111111111	1	(T						
UD,		30. Name and a	Over and	who completed cause of				Doll-i-	- No.		1201	
1 /2		31 Data filed /4	Honth, Day, Year)	1114) 1111	trar's Signatura	renn	screet	, Baltimo	ore, Mar	y Land 2	1201	
Št: Regist	ate	ST. Data filed (A	SEP 13	2000 32. Regis	nar's Signatura	19	Some	1				
ricgist	out .		1			/-	THE CONTRACT					

Registrar



State of Maryland / Department of Health and Mental Hygiene

Physicia	_	1. Decedent's Name (First, Middle, Last)	2. Dete of D Month	Day Yes		
/Medica Examine	al -	MIRIAM S VAN GELDER  4a Facility Name (If not institution, give street and number)  4b. City, Town,	or Location of Dea	th 4c. County of De		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 I	MORE Irs. 8. Date of B	BALTI inth years 9. E	MORE  Sinthplace (State or Foreign country)  Sachusetts	
Director	1	Usual Residence of Decedent	July .	10,1906 Mas	sacnusetts	
how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 2 No	
Se-f	Director	Maryland Baltimore Catonsville				
23e or 2	ra Dir	10e. Street and Number 221 Gralan Road 21228		10g. Citizen of What USA		
urs our	by Fur	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Yeer or Dates:  13. Was Decedent of Hispanic Origin?  If Yes, specify Cuban, Mexican, Put Yes, Give Yeer or Dates:	(Specify Yes or Nuerto Rican, etc.)	Black, W	merican Indian, hite, etc. Thite	
A I A I D-UUAU d within 72 hours al giene. r than *netural*, or i v. Weden Erm	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  5+College (1-4or 5+)  Doc for	working	16b. Kind of Busine	ss/Industry	
aryland Z1Z should be filed withir ad Mentel thygiene. marked other than matic event, tra the	E 0	Boccor		State of	Maryland	
2 5 5 5 C	Be			e, Maiden Sumeme)		
ire, Mar yiano s 1 and 2 should be file if Heelth and Mentel Hy them 27 is marked oth other traumatic event	2	William Grant Seaman Laura  19e. Informant's Neme/Reletionship (Type, Print)  19b. Mailing Address (Street and Number or			a. Zip Code)	
nd 2 alth er trau		Helen L. VanGelder 221 Gralan Road Ca				
0 0 - 7		20a. Method of Disposition  1 Burial 2 Cremetion 3 Removal from Stete  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, cremetory or other place)  Chesapeake Crematory	Date	20c. Location - City		
Demit. Pag Department Important: P eny Injury o		21. Signature of Funerei Servipe Licensee  22. Name and Address of Fecility Sterling-Ashton- 736 Edmondson Ave				
- M		23a. Part1. Enter the disease, Vr complications that caused the death. Do not enter the mode of dying, such as care shock, or heart failure. List only one cause on each line.	diac or respiratory	errest,	Approximate Interval Between	
Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death)  a. ATRIAL FIBRILLATION WITH RAP Due to (or as a consequence of):	D VENTA	RICULAR RAT	6	
ficata be physicie as the bur	Aedicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):				
death cartif	Physician/M	d.  Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Di	d tobacco use contrib	ts to the cause of death?	
bet the detech	by Phys				Probably 4 Unknown	
Physician: The law requires the law requires the law requires the law requires the law red director, page 2 should be	Completed b			is an autopsy formed?	b. Were sutopsy tindings available prior to completion of cause of death?	
The le	SO		10	Yes 2 No	1 ☐ Yes 2 No	
Physician: The this certificate ral director, pag	103	axaminer?	Death (Check only			
2 2 2	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident   1 Inpatient 2 ER/Outpatient 3 DoA   Other: 4 Nursin   28a. Date of Injury (Month, Dey Year)   28b. Time of Injury Work? 2 Accident   1 Inpatient 2 ER/Outpatient 3 DoA   Other: 4 Nursin   28b. Time of Injury Work? 1 Yes 2 No		sidence 8 Other (S e how injury occurred	(specify)	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral or a second secon	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location City or T	(Street and Number of own, State)	Rural Route Number,	
To the Hospital within 24 hours a To the Funeral Completely filled	edical C	29a. Certifier (Check only one)  Check only one)				
vithir To th comp	District Co.	29b. Signature and title of certifier 29c. License number		29d. Dete signed (M	onth, Dey, Year)	
		Neeraj Verna MD P 14412		SEPTEMBE	R 06 2000	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 SAMAR I'DRNEERAJ VERMA 5601 LOCH RAVEN	BLVD HOS	BALTIM	ORE MD 2123	
State Registra	-	31. Data filed (Month, Dey, Year)  32. Registrar's Signeture	-			



Certification: To the

this

after death.

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To the Hospital within 24 hours

6

completely

edicai

Division Attending Be 25. Was cesa refarred to medicel 27. Mannar of Death

26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidance 6 Nother (Specify) AT SCENE 28d. Dascribe how injury occurred decedent hanged 28b. Tima of 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? A

fourity: 7:30 5 Panding invastigation 1 Yas 2 No 9/9/00 6 Could not be detarmined street

28f. Location (Street and Number or Rural Route Number, City or Town, State) 803 S. Ellwood Avenue (rear) Baltimore, Maryland 28a. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mennar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and mannar stated.

O.C.M.E

(Check only one) 29b. Signatura and title of certifiar

1☐Yes 2☐ No

1 Natural

2 Accident

37 Sulcida

29a. Cartifiar

4 Homicida

29c. License number FOR

29d. Data signed (Month, Day, Year) SEPT. 9, 2000

30. Nama and addrass of person who completed ceusa of death (Itam 23a) (Type, Print)

David Fowler, M.D.

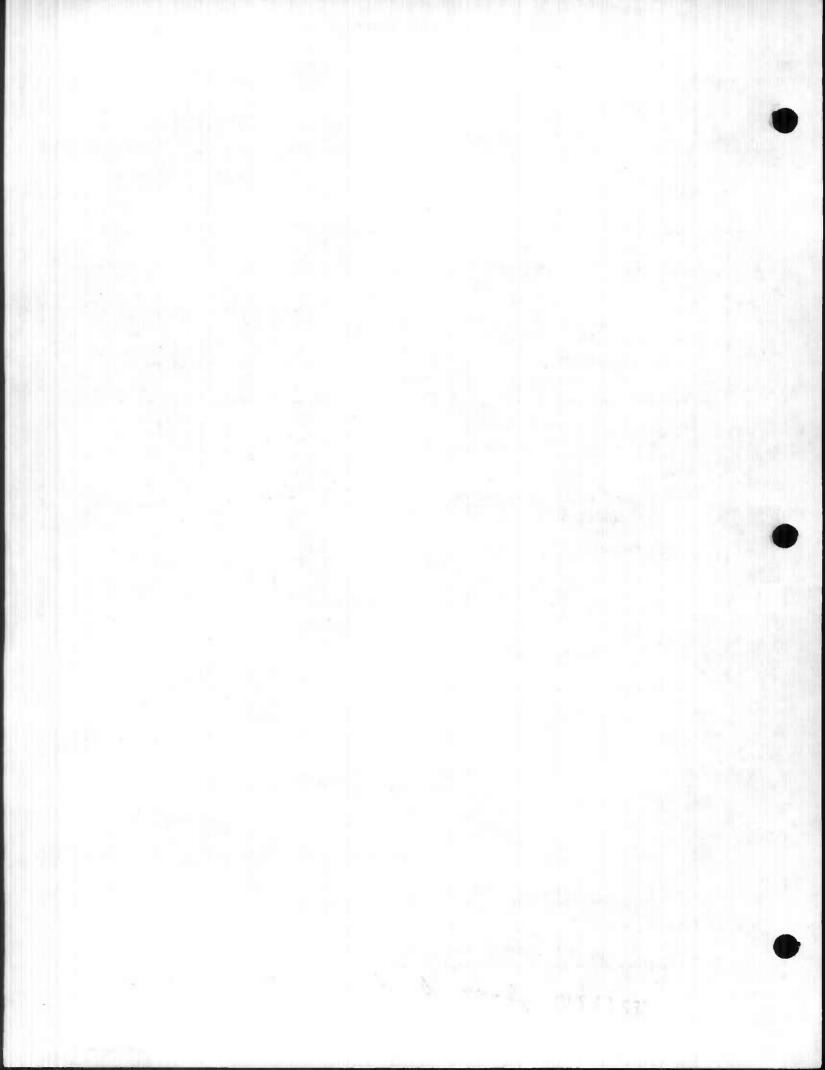
SEP 13 2000

34 Addistrar's Signature

1112 Penn Street, Baltimore, Maryland 21201

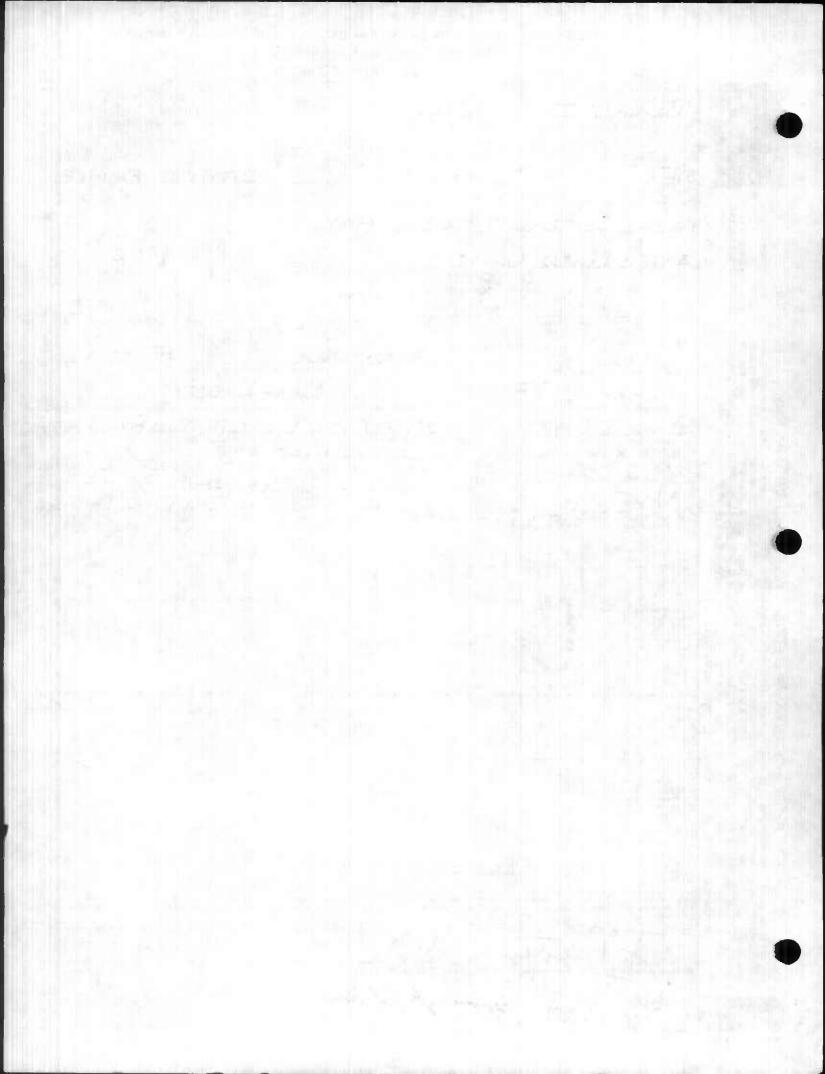
himself

State Registrar



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	em 23a,27,28a,b,c,d,e,f	Last)	0/00 340104	10 01 2		2. Dete of Dee			3. Time of Death	
Physician (Martina)		if sno	1K/2			Septemb	Day Der 04.	Year 2000	8:10 A.	
/Medical Examine	4. Easilit Name (Mast Institution of			4b.	. City, Town, or L					
	Peninsula Region	nal Medical Cer			alisbur	У	Wico	mico		
uneral		Sex 7. Age (In yr.	Months		If Under 24 Hrs. Hours Min.	8. Defe of Birth (Month, Day	h /, Year)	9. Birthpl Count	ace (State or Ford	
irector	216 66 5439	44	Yrs.			BEPT:17	1955		RIDA	
ž	Usuel Residence of Decedent  10a. Stata 10b. County	10c. C	City, Town or Location					10	Od. Inside City Lim	
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or 28s-f.	10e. Street and Number	121021		ip Code			10g. Citizen of What Country?			
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iner mast	11. Merital Stetus	12. Wes Decedent Ever in	U,S. 13. Wes Dec		panic Origin? (Sp. Mexican, Puerto	ecify Yes or No-	14. Rac	a - Amarica		
miner	1 Never Merried 25 Merried	Armed Forces?				Hican, etc.)		ck, White, e	etc.	
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10 P	21. Signatura of Funeral Service Life	ersse )	22. Name	end Address	of Facility	HAPIL-	-BXLA	iR,P	A- 210	
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	23a. Pert1. Enter the disease, or on shock, or heart failure. List on	mplications that caused the de ly one cause on each line.	with. Do not enter the mo	ode of dying,	such es cardiac	or respiretory ar	rest,	,	Approximate Interval Between	
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Die to	4 Homicide	found at home				Princess	Anne Md.	33 Circ	cle Drive	
_ 0	29a. Certifier 1 Certifying I	Physician: To the best of my ki	nowledge, deeth occurre	d et the time	, dete end piece	end dua to the	cause(s) and m	anner as si	ated.	
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e Funeral	29b. Signature and title of cardifier		111 1 2	9c. License	number		29d. Date signe	d (Month,	Day, Year)	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item320b perFHG787 9/15/2000 EW Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Mary 4b. City, Town, or Location of Death 4c. County of Death /Medical 4a Facility Name (If not institution, give street and number) Examiner Battimore City HOSPITAL The Johns HODK: NO If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Months 75 219-10-1608 Yrs JAN. 14, 1925 FLORIDA Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow 1 Yes 2 No Director 288-1 MARYLAND ANNE ARUNDEL MILLERSVILLE 10g. Citizen of What Counfry? 10e. Street and Number 10f. Zip Code b must be U.S.A. 8303 BROOKWOOD ROAD 21108 238 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. Yes 2 No 1 Never Merried 2 Merried 1 Yes 2 No Specify WHITE 8 Specify: ğ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SCHOOL BUS DRIVER PUBLIC SCHOOLS 1 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental LEWIS DICE MARGARET CRONLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MR. ROBERT L. WAGNER (HUSBAND) 8303 BROOKWOOD ROAD, MILLERSVILLE, MD. 21108 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Department Important: If any injury or CHESAPEAKE CREMATION CENTER, LLC. STEVENSVILLE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Livense 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 Approximata Interval Between Onset and Death 23a. Part1. Enter the due and or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fullure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner fibrillation atrial monte Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last the Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Winknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospitel: 1 Anpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 this funeral 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 10 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident

Box 68760. P.O. Records, of Vital Division or Attending To the Hospital o within 24 hours at To the Funeral Di completaly filled i

altimore, Maryland 21215-0020

6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homloide Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 000 my mobride September 10, 2000

State Registrar

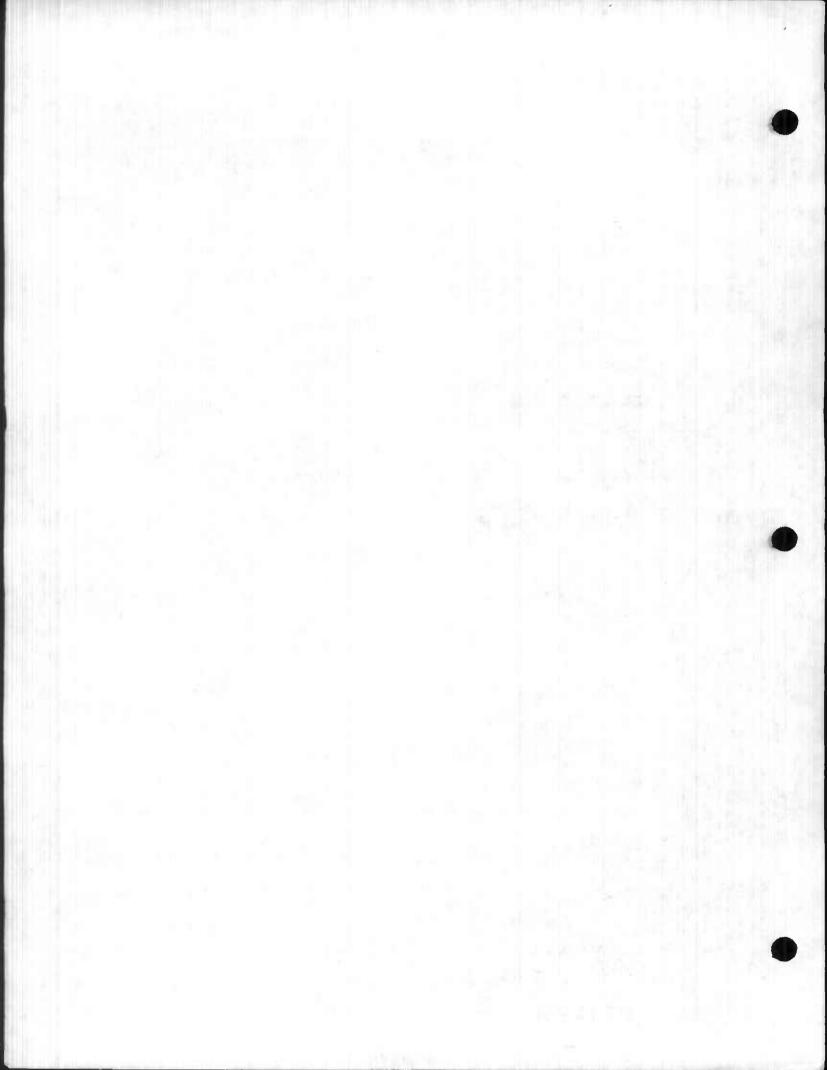
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30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)
Luy Mc Bride, Johns Hopkins Hospital, Baltimore, Maryland 31. Defe filed (Month, Day, Year)

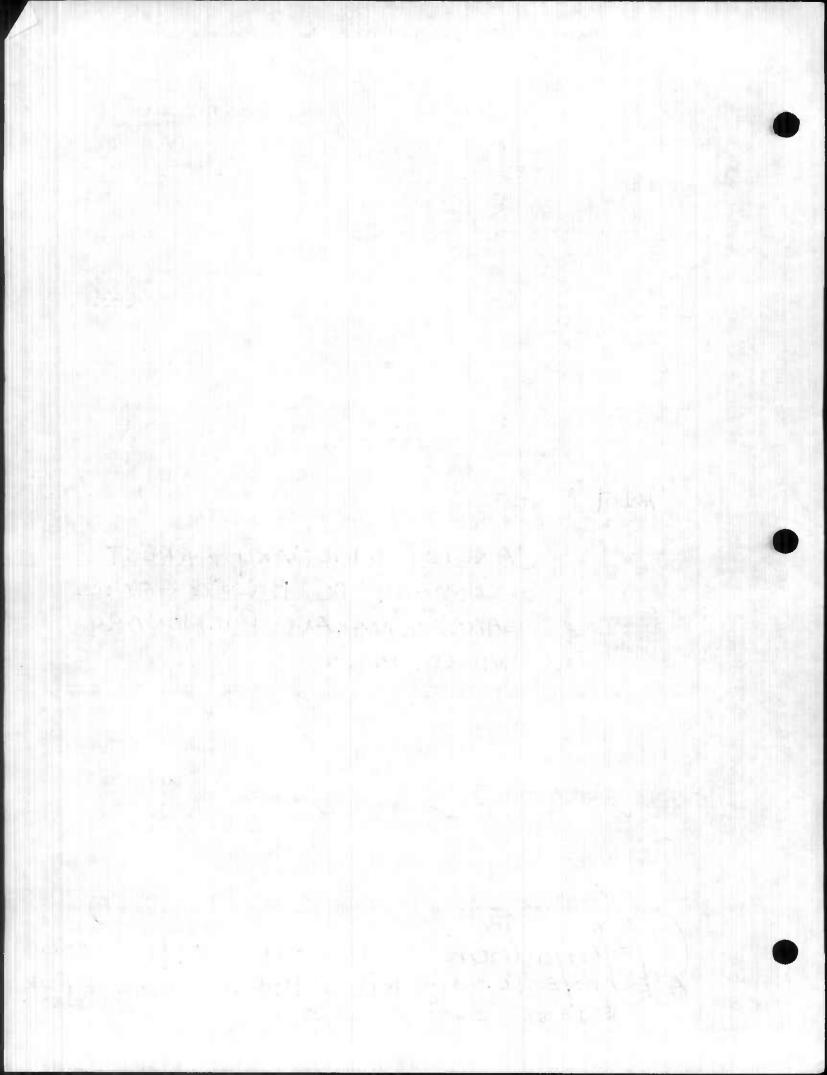
SEP 1 3 2000

32. Redistrar's Signature



State of Maryland / Department of Health and Mental Hygiene 2901

	Ce	rtificate of Death	Reg. No.	00 23013	
Dhaminian	Decedent's Name (First, Middle, Last)		2. Date of Death Month Dey	3. Tima of Death	
Physician /Medical	Louanna Wright		0 1-0 -	000 9:30aim	
Examiner	4e Facility Name (If not institution, give street end number)	4b. City, Town, or Lo	cation of Death 4c. Co	ounty of Death	
Funeral Director	5. Social Security Number 213-22-1938 6. Sex 1 M 2XX 7. Age (In yrs. lest birthdey, 91 yrs.	Sever of Under 1 Yeer of Under 24 Hrs.  Months Days Hours Min.	8. Dete of Birth (Month, Day, Year)	9. Birthplece (Stete or Foreign	
h the Maryland r 28a-f show Inchrastal	Usual Residence of Decedent  10e. State Md • 10b. County Anne Arundel 10c. City, Town or Li	ocation Severn	10d. Inside City L 1 □ Yas 2 <sup>3</sup>		
ath with the Mar 123s or 28s-f si 1810s noticed and Director	10e. Street and Number 7906 Popular Grove Road	10f. Zip Code 21144	10g. Citizer USA	n of What Country?	
urs after de al', or ham Euronean by Fune	11. Meritel Stetus  1 Never Merried 2 Merried  12. Was Decedent Ever in U,S. Armed Forces?  1 Yes 2 XXXX  If Yes, Give Yeer or Detes:	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☐ No Specify:	Rican, etc.)	. Rece - American Indien, Bleck, White, etc. Black	
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2 shd and la ma	son	ing Address (Street end Number or Rura • Box 491 LaFaye			
Pages 1 and tent of Heelth int: if them 27 iry or other to	20a. Method of Disposition 20b. Plece of Disposition complete, cre		Date 20c. Loca	ma 36862 tition - City or Town, State anover, Md.	
permit. Pag Department Important: I any Injury o	21 Signature of Funeral Service Licensee	2. Name and Address of Fecility Nut 2501 Gwynns Fall	tter Funer	al Homes, Inc. 1timore, Md.	
	23a. Pert1. Enler the disease, or complications that caused the death. Do not en shock, or heert fellure. List only one ceuse on each line.			Approximata	
death certificate be assocuted e attending physician and ed for use as the burial-transit sician/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consect of the conditions of the consect of	quence of):  MA.AND   quence of):	PULMO		
death ce attendii d for use	Pert II. Other significant conditions contributing to death but not resulting in the	underheine cause given in Dert I	23h Did tohacco us	se contributs to the cause of death	
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sw requires to been so a b			24a. Was en autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of deeth?	
The In			1 □ Yes 2 🗇	No 1 Yas 2 No	
certificate rector, pag	25. Wes case referred to medical	26. Place of Deet	h (Check only one)		
Physician: this certific ral director, To Be (	examiner?  1 Yes 2 No Hospitel: 1 Inpetient 2 ER/Outpetie	Other:	me 5 Residence 6 (	Other (Specify)	
E E =	27. Manner of Death  1 Neturat 5 Pending (Month, Day Year)  2 Accident Investigation 28a. Date of Injury (Month, Day Year)	of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how injury of	occurred	
	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Plece of Injury - At home, ferm, st building, etc. (Specify)	reet, fectory, office	28f. Location (Street and City or Town, Stete)	Number or Rurel Route Number,	
Ne Hospi n 24 hou Ne Funer pletely fill edical	29e. Certifier  1. Certifying Physician: To the best of my knowledge, deel 2 Medical Examiner: On the basts of examination and/or in and menner stated.	nvestigetion, In my opinion, deeth occurr	red at the time, dete end p	lace, and dua to the cause(s)	
To the company	Signature for Alle of certifier	29c. License number 0.4.2.0.4.1	29d. Date	signed (Month, Day, Year)	
x-15	Name and address of person wto completed ceuse of death (Item 23a) (Type	Print), Print)	Acute Br	Tribe (un Parl	
State Registrar	31. Date filed (Month, Dey, Year) 32. Register's Signeture SEP 1 3 2000	5 South	21.51	2 1225	



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dey Month Year DENNIS 702 PM ALTHER SEPTEMBER 12 2000 Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PALTIMORE ADMINISTRATION MEDICAL CTR Min. A Dril 12 BACTIMORE VETERANS' BALTIMORE CITY 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 110 M 2□ F 215-40-7487 58 Md. **Usuat Residence of Decedent** 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Md. N/A Baltimore Mes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 4127 Hague Ave U.S.A 12. Was Decedent Ever in U.S. Armed Forces? \*(2)Ves 2 □ No If Yes, Give Year or Dates: 1968 Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 1 Never Married 2 Married 1 XYes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 12th College (1-4or 5+) New Harbor Cab Co. Cab Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ethel C. VanPelt Doyle Alan Alther 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 Mulberry Ridge Ct. Pasadena Md. 21122 Theresa Forbes/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Vet. Cemetery 9/18 Crownsville, Md. 22. Name and Address of Facility Gonce Funeral Home P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Hwy. BAlto. Md., plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Interval Between Onsat and Death tmmediate Cause (Finel disease or condition resulting in deeth) METASTATIC LUNG 1 year Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting In the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 12 Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 ☐ Yas 2 ☐ No 25. Was case referred to medical examiner? 26. Piace of Death (Check only one) Hospital: 1 Denpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 200 No 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1, Natural 1 Yes 2 No

Physician/Medical Examiner The law requires that the death certificate be axecuted the burial-transit Box 68760, for use as signed by the a d be detached f of Vital Records, P.O. þ page 2 should Completed certificate has or Attending Physician: Be Certification: To this After Division

the funeral s after death. à

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r then "netural", or items 23e or 28e-f show the Wedical Examinar must be notified at

"natural"

i Hyglene. other then

permit. Pages 1 and 2 should be filled w Department of Health and Mentel Hygler Important: if Item 27 Is marked other th eny Injury or other traumatic avent, the page.

**Physician** 

/Medical

Examiner

Director

Funeral

py

Completed

with the Maryland

death

filed within 72 hours after

Baltlmore, Maryland 21215-0020

To the Hospital o within 24 hours at To the Funeral Di Medical completely State

filled in

31. Date filed (Month, Day, Year) SEP 14 2000

C. ABRAHAM

6 Could not be

5/1/sraham

RESIDENT , NTOWAL MED # 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16 SOVIH Entar Street

32. Registrar's Signature

YENIOR

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 nd floor (MEDICAL CUMC), BALTO-, MO 21201 Darks

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the causa(s) and manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated.

29c. License number

045501900

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

SERTEMBER 13, 2000

Registrar

29b. Signature and title of certifier

2 Accident

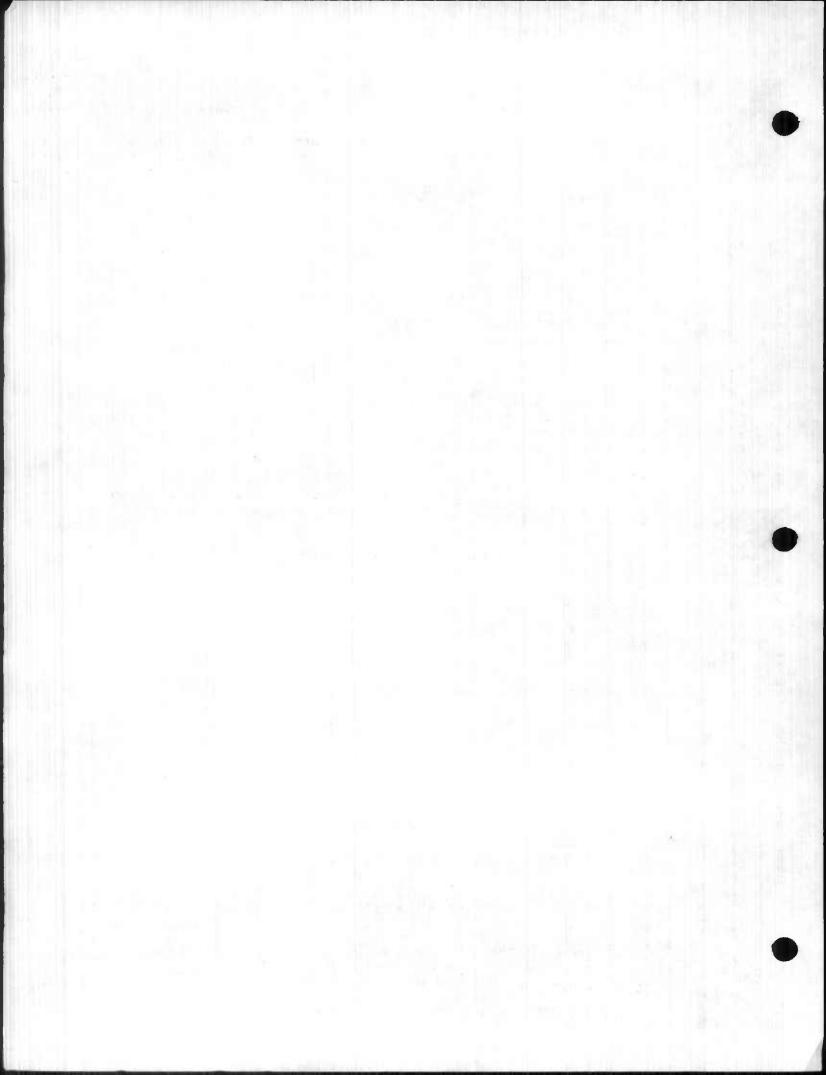
4 Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

TITUS



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dey Year Month **Physician** Amanda M. Aler 5:45 AM September 13, 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Charlestown Retirement Community/Care Ctr. Catonsville Baltimore If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Days Houra Montha 1□ M 21XF 100 Director 705-03-8045 July 13. 1900 Maryland Usual Residence of Decedent the Manyland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ahow must be notified at 1 Yes 2 No Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code TO 707 Maiden Choice Lane 21228 United States deeth Funeral Neme 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Maritel Stetus "netural", or item be filed within 72 hours after of tal Hygiene. d other than "netural", or flem event, tre Heolea Emmon 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 1 Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ Specify White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Heelth end Mental If item 27 is marked or other traumatic ev John Aler 2 Amanda E. Addison 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herbert T. Fee, Jr. / nephew 612 Worcester Rd Baltimore, MD 21286 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition

2 □ Cremetion 3 □ Removel from Stete Dete 20c. Location - City or Town, State permit. Page Department of Important: If eny injury or pace. 4 ☐ Donetion 5 ☐ Other (Specify) 9/15/00 Baltimore, MD Loudon Park Cemetery 21. Signeture of Funerei Service Licensee 22. Name end Address of Facility CAFA Stephen D. Lohrmann, P.A.
8717 Green Pastures Dr., Towson, MD
23a. Pert1. Enter the disease, or complications the cause on each line.

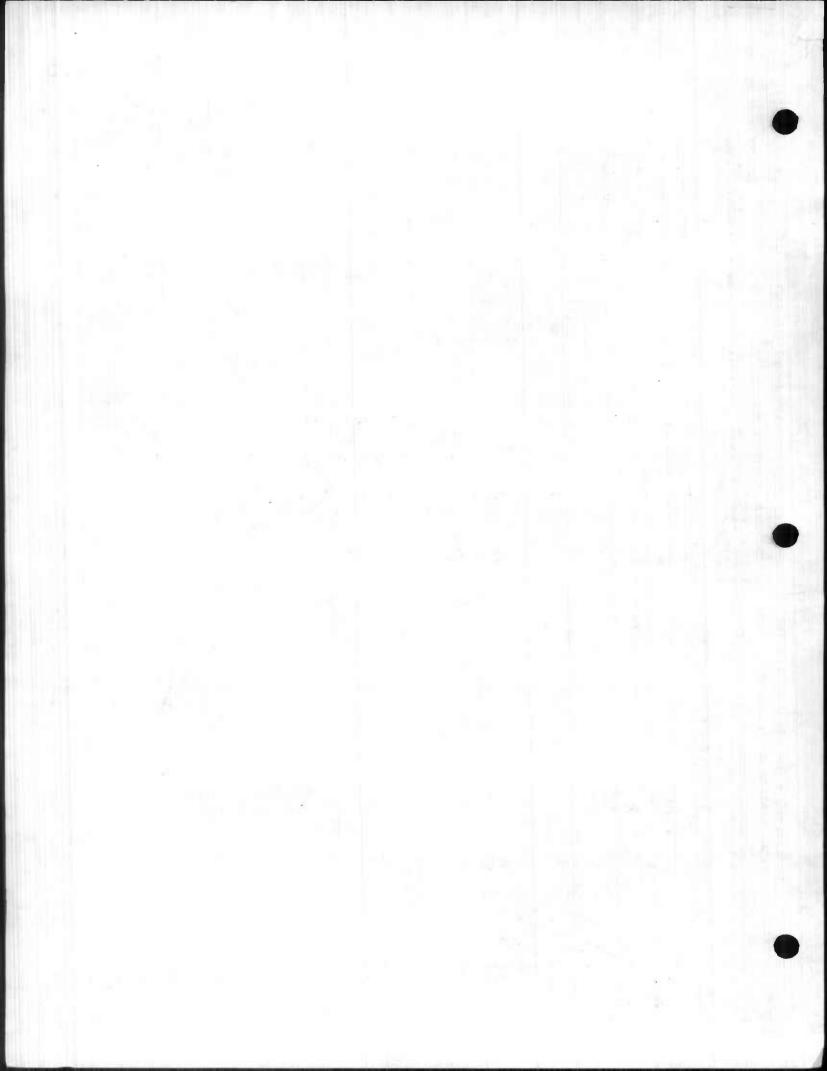
Do not enter the mode of dying, such as cardiac or respiratory errest, 21286 Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Finei disease or condition resulting in deeth) /Medical nermonia Days Examiner Due to (or as a consequence of) Examiner be axecuted Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last pue Due to (or as a consequence of): Box 68760. physician Physician/Medical Due to (or as a consequence of): the USB signed by the a Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yas 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? should 24a. Wes an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital certificate Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: A Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 1 Yes ANO 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division After PS Neturat 5 Pending 1 Yes 2 No n 24 hours efter death we Funerel Director: // bletaly filled in by the f death. 2 Accident investigetion 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 - Homicide 6 Hospital edicai 29e. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) end menner steted. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier MA DYZYYZ 30. Name and access of person who completed cause of death (Item 23a) (Type, Print) Lane (chons : 14 May 12 . 21228 10 64715 Marida Choice 711 32. Registrar's Signature

**DHMH 16 Ray 6/95** 

State

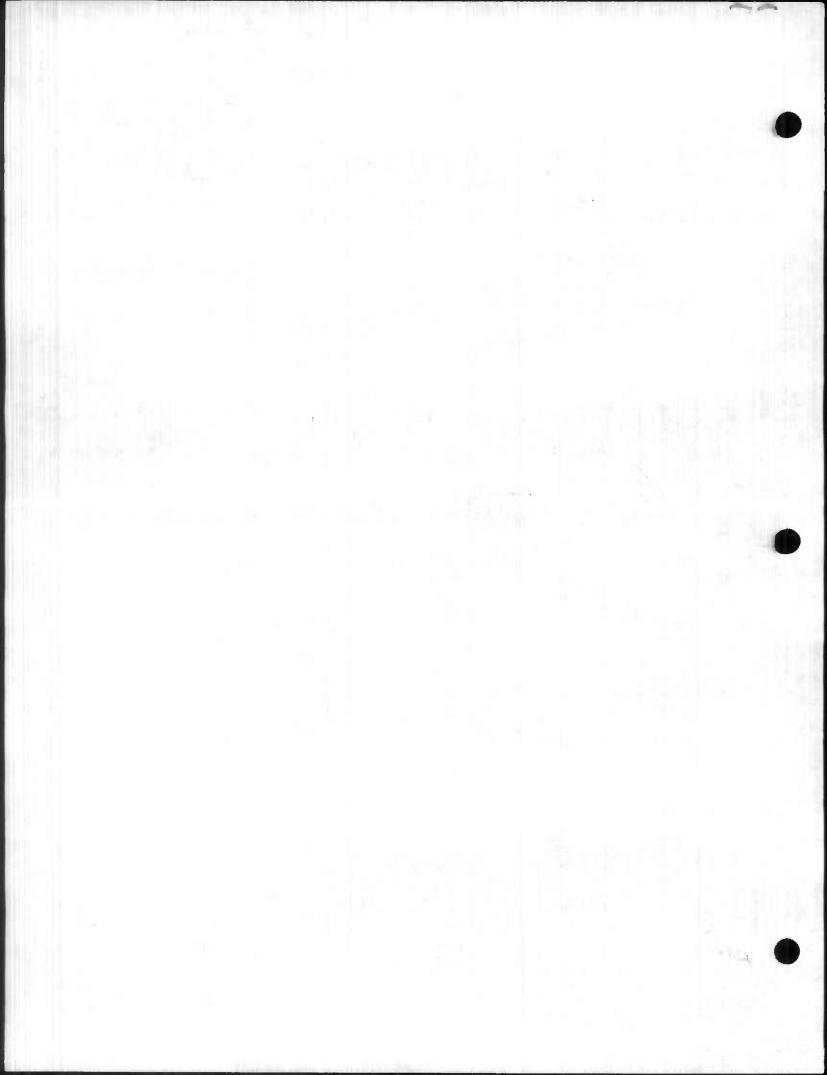
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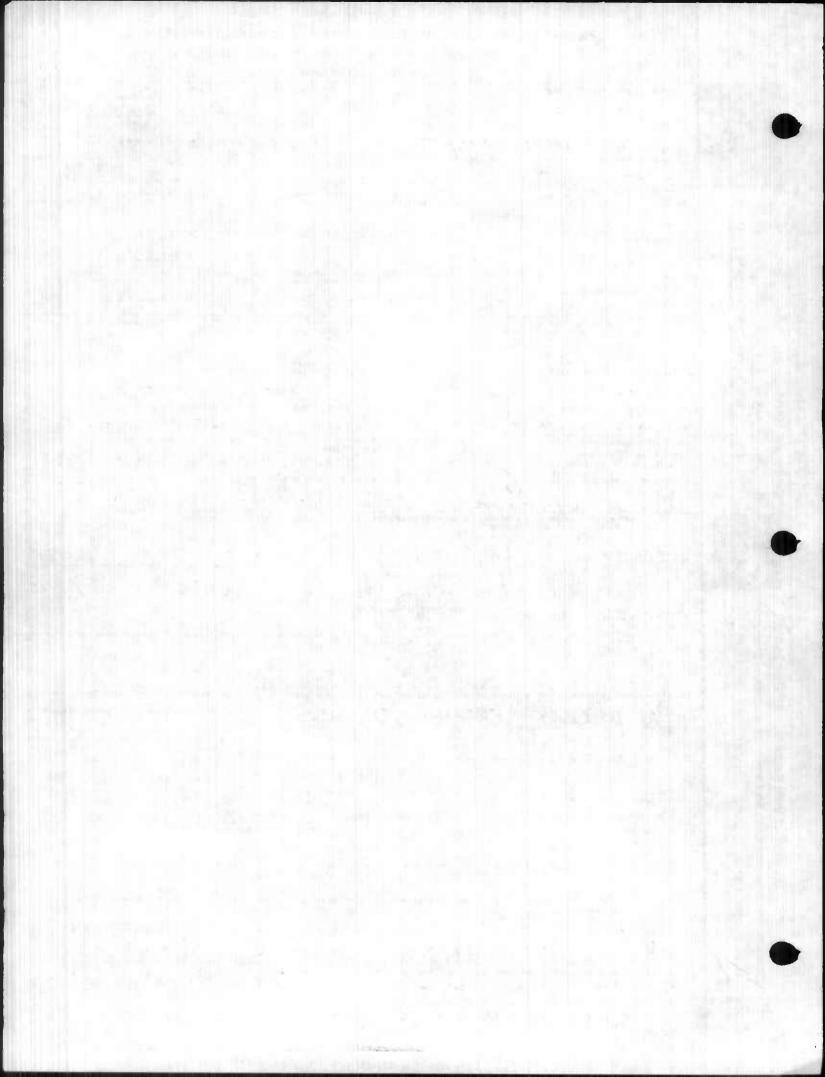
State of Maryland / Department of Health and Mental Hygiene 00 29016

				Cer	tificate of	Death			Reg. No.		010	
Physician /Medical	1. Decedant's Name (First, Midd Floyd	lla, Last)	Biv	ens				2. Data of De Month Septem	ber 11,	Year	ima of Deeth 1646 pm	
Examiner	4a Facility Name (If not institution Union Memorial.		er)				imore	eation of Death	4c. County N/A	of Death		
Funeral Director	5. Social Security Number 213–26–4608	6. Sex 7.	Aga (In yrs. last b	virthday) Yrs.	If Undar 1 Year Months Days	If Undar Hours	24 Hrs. Min.	8. Data of Bird (Month, Da		9. Birthplaca (S Country)	Stata or Foraign	
with the Maryland a or 28a-f show be notified at	Usual Rasidence of Decedant  10a. Stata  10b. Count  MD	, NA	10c. City, To	wn or Loc						10d. Inside City Limits 1 ☑ Yes 2 ☐ No		
of the Ma or 28a-f s be notified	10e. Street and Number			10f. Zip Code					10g. Citizen of What Country?			
her death w there 23a foer must b				21218  n U.S. 13. Was Decedent of Hispanic Origin? (Specify Yas					USA (as or No- 14. Race - American Indian,			
5-0020 72 hours after death v 72 hours after death v 73 hours after death v 81cat Examiner must	3 Widowed 4 □ Divorce	If Yas, Giva	as? If Yas, specify Cuban, Maxical □ No 1 □ Yas 2 □ No Specify:			Specify:	faxican, Puarto Rican, etc.)			k, White, atc.		
1 21215-0 ed within 72 ho vglens. er than "natur it, the Medical.	15. Decede (Specify only hight Elementery/Secondery (0-12)	nt's Education ast grada complated)  Collega (1-4c	or 5+)	(Giva I lifa. E	ent's Usuel Occup kind of work dona OO NOT use retire	during mos d)	t of workin	g		Post Of	ffice	
Maryland 21215-0020 to 2 should be filled within 72 hours at 1th and Mental Hygiene. The marked other than "natural", or treumatic event, the Medical Examp To Re Commission by 8	17. Father's Name (First, Middla	, Last)	ivens	BC C	001	18. Moths	ar's Name Ada	(First, Middla,	Maidari Sumam	Jones		
	19a. tnformant's Neme/Reletion Valerie	ship (Type, Print) Bivens	2	9b. Mailin 2557	g Address (Straat Kirk A	venu	er or Rura e Ba	Routa Number	er, City or Town, re, Ma	State Zip Code ryland	21218	
Baltimore, samil. Pages 1 ar Appartment of Hear Importants If item importants If item into Injury or other ince.	20a. Mathod of Disposition  1 Burial 2 Cramation 4 Donetion 5 Other (		an mad	tone oran	sition (Neme of setory or other pla n Fores	ce) t VA	Cem	Data 1. 09-		O Owing	tate MD gs Mill	
Departm. P Departmi importan eny injur	21. Signature of Funeral Service of Facility  Baltimore, Maryland 212  WM.C.March FH 1101 E. North Avenue											
Physician /Medical Examiner	Immediata Causa (Final disease or condition rasulting in death)  Sequentially list conditions, if any, leading to immediata cause. Entar Undertying	a Arterio	Due to (or as	a conseq	uence ot):	cular	Dise	ease			at and Death	
x 6876( entificate be ding physicia se as the bur	Causa (Disaase or injury that initialed avants resulting in death) Last	c	Due to (or as a	a consequ	uence of):							
P.O. Bo. at the death c d by the attendetected for us	Part It. Other significant conditi	ons contributing to deat	h but not resulting	in the un	idarlying causa gi	ven in Part 1	t.	23b. Dld	tobacco ues co	ntribute to the c	ause of death?	
. 5 60 >		ructive Pulr	monary D	isea	se,						<b>∳</b> QXUnknown	
s been s 2 should		litus						perfo	an autopsy ormed? ection	available	ion of causa	
- F # a U									Yas 2⊠No	1 □ Yas	21XNo	
Of Vital Physicien: The this certificate ral director, pag. To Be Co.:		Hospital:			Ot	her:		(Check only				
To the side in		28a. Data of I		Tima of Injury	28c. Inju	4∐ Ni iry at ork? ] Yas 2 □	2		dance 6 □Oth how injury occur			
	3 Suicide 6 Could deten	mined Zoa. Place of	Injury - At homa, , etc. (Specify)	farm, stra	aat, factory, office		2	28f. Location ( City or To	Street and Numb wn, Steta)	per or Rural Rou	ta Number,	
Hospi 4 hou Funer listy fill	29a. Cartifier 1 Certifyi (Check only one) 2 Medica	ng Physician: To the be I Examiner: On the basis and manner	s of axamination								ause(s)	
To the within 2 To the comple	29b. Signature and title of certifi	1.1	M.D.		29c. Licen:				29d. Date signe Septembe	od (Month, Day,		
OBs	30. Name end address of person MALY G.  31. Date filed (Month, Day, Year	RIPPLE, M		i) (Type,		on Sta	reet,	Balti	more, Ma	aryland_	21201	
State Registrar	SEP 14	4	neva	9	Spark	2						



		Cort		ealth and Mental I	U	0 29017	
	AMEND#18 PER F.H. G789 11-28-2000 JAB Certificate of Death  1. Decedent's Name (First, Middle, Last)				Reg. No. f Death	3. Time of Death	
Physician	Norman Henry Becker				) gay 2/	Year (:35 PH	
/Medical Examiner	4a Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death						
(C)	North Avundel Hospital Anne AvunderAnne Arundel						
Funeral Birector	212-22-4173 1XM 2 F	(Inlyrs. last birthday) Yrs.	Months Days	Hours Min. 8. Date of (Month)	Birth Dey, Yeer) 23 1926	9. Birthplace (State or Foreign Country) Maryland	
Mary Mary more should be should be should be marked by any or the marked by any or the marked by any or the should be should b	Usuel Residence of Decedent  10a. State 10b. County	10c. City, Town or Loca	ation			10d. inside City Limits	
	Md. Anne Arundel Pasadena						
	10e. Street and Number	10e. Street and Number 10f. Zip Code			10g. Citizen of W	hat Country?	
	1411 Woodland Beach Rd.		21122		U.S.	A	
	11. Marital Status 12. Was Decedent Evarmed Forces?	ver in U,S. 13. W	13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica		y Yes or No- an, etc.) 14. Raca - American Indian, Black, White, etc.		
	1 Never Married 2 Married 1X Yes 2 No. If Yes, Give Year or Dates: 1	0 11	1 ☐ Yes 21CMNo Specify:			Specify: White	
	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)			ition uring most of working	16b. Kind of Business/Industry		
	Elementary/Secondary (0-12) College (1-4or 5+)				Trucking		
	8th 17. Father's Neme (First, Middle, Last)		TIVEL	18. Mother's Name (First, Mi			
	Henry E. Becker Sr.			NORMA JORY	hns Beck		
	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street a	and Number or Rural Route N			
	Margaret Becker/ Wife	1411	Woodlar	nd Beach Rd	Pasaden	a Md. 21122	
Ore of the rest	20a. Method of Disposition  \$\text{\$\mathbb{K}\$} \Burial 2 \Burial \text{Cremation} 3 \Begin{array}{cccccccccccccccccccccccccccccccccccc	20b. Place of Disposi cemetery, cremi	ition (Neme of etory or other plece	Date Date	20c. Location - 0	City or Town, State	
Baltimore Semil. Pages 1- somit. Pages 1- soprometral filter myortant if law my injury or othe	4 □ Donation 5 □ Other (Specify)			Park 9/13		rnie Md.	
Ball Semil	21. Signature of Funeral Service Licensee			s of Facility Gonce			
- 452.0	4001 Ritchie Hwy. BAltimore Md. 21225						
Physician /Medical	23a. Párt1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death)  Que to (or as a consequence of):						
							Examiner
ovacuted in and intransit							End
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Compared to the cause of injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):						
a prie de							
(D) = = 0							
Box 6 eath certifi attending for use as	d.						
P.O. at the d by the betached	Part it. Other significant conditions contributing to death but	t not resulting in the und	derlying cause give	en in Part t. 23b.	Did tobacco uss con	tribute to the cause of death?	
	Reripheral Arterial disease			e	1 ☐ Yes 2 ☐ No	3 Probably 4 □ Unknown	
dS, Puires that is signed to detect de				248.	Was an autopsy	24b. Were autopsy findings	
cord  * require  been si should I					performed?	available prior to completion of cause of death?	
II Rec				PART BATT	1 Yes 2 No	1 DYes 28 No	
f Vita ystelen: is certifica director.	25. Was case referred to medical 26. Place of Death (Check only one)						
	examiner? 1 Yes 2 No  Hospital: 1 Department 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
On O O ding Ph h. After thi funeral funeral tion: 1	27. Manner of Death 1 ☑Naturat 5 ☐ Pending (Month, Dey	Year) 28b. Time of Injury	28c. injury Work	et 28d. Desc	ribe how injury occurre	be	
isio trendi death ctor: A y the f	2 Accident investigation 3 Suicide 6 Could not be 280 Place of Jolius	- At home form stee		fes 2 No	on /Street and Number	or or Purel Poute Number	
Division of Attending and a fate death of the function of the	3 Suicide 4 Homicide  5 Homicide  4 Homicide  4 Homicide  5 Homicide  4 Homicide  5 Homicide  6 Homicide  7 Homicide  8 Homicide  8 Homicide  8 Homicide  8 Homicide  8 Homicide  9 Homicide  1 Homicide  2 Homicide  2 Homicide  2 Homicide  2 Homicide  2 Homicide  2 Homicide  3 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  5 Homicide  5 Homicide  6 Homicide  8 Homicide  8 Homicide  8 Homicide  9 Homicide  1 Homicide  2 Homicide  2 Homicide  2 Homicide  3 Homicide  4 Homicide  4 Homicide  5 Homicide  6 Homicide  8 Homicide  8 Homicide  8 Homicide  9 Homicide  1 Homicide  2 Homicide  2 Homicide  2 Homicide  2 Homicide  3 Homicide  4 Homicide  5 Homicide  6 Homicide  8 Homicide  8 Homicide  8 Homicide  9 Homicide  1 Homicide  2 Homicide  2 Homicide  3 Homicide  4 Homici						
Division O  To the Hospital or Attending Ph within 24 hours stated dealth. Completely filled in by the funeral Medical Certification:	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.						
To the complex	29b. Signeture and little of certifier 29c. License number 29d. Date signed (Month, Day, Year)					(Month, Day, Year)	
1./	Ny In House	Myscia.	DE	5642	Sep. 9	2000	
21/	30. Name and address of person who completed cause of death (frem 23a) (Type, Print)  X/DOZHOU 35/HOSPital drive Glen Burnie Mp. 2106/						
0	21 Date fled Month Day York	05/) irtal	drive	allen	13 UMIII	-MP.CIO	
State Registrar	31. Date filed (Month, Day, Year)  SFD 1 4 2000	s Signature	Spork	á			

DHMH 16 Rev 6/95



Please Type or Print In Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death SEPTEMBER, NINE, 2000 **Physician** ROBERT KROWN 0113 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Hi mone TOPKINS Da If Under If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 1-26-1943 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours 1 1 M 2 □ F Yrs 218-40-7684 57 Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show MD 1 Ves 2 No must be notified n/a Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 3253 E. Baltimore Street 21224 USA Name 23a Funeral 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Wes Decedent Ever in U.S. Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 ☐ Never Merried 2 ☑ Merried Specify: White Baltimore, Maryland 21215-0020 "nathurs", or 1 Yes 2 No Specify þ 3 Widowed 4 Divorced Completed event, the Medical 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within al Hyglene. City of Baltimore Elementery/Secondery (0-12) College (1-4or 5+) Supervisor Water Dept. 10th 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) h and Mental Is marked of Robert Brown Virginia Bridges 19e. Informent's Neme/Reletionship (Type, Print) wife 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) I and 2 important of Health at any Injury or oth odds. 3253 E. Baltimore St., Baltimore, Maryland 21224 Mary Brown 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 9/12/00 Baltimore, Maryland Sacred Heart of Jesus 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph N. Zannino, Jr. Funeral Home 21. Signeture of Funerel Service Licenses 263 South Conkling Street, Baltimore, Maryland 224 area 23e. Pert1. Enter the disease, or compricetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart teilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examine ardiogenic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last P.O. Box 68760, ettending physician acute The law requires that the death certificate be Physician/Medical 88 years Ovonaur Slase Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 No 3 Probably 4 Unknown Records, p 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? page 2 should Completed certificate has 2 NO 1 Yes 1 Yes 2 No Division of Vital aptrat or Attending Physician: The hours after death.

Indexed Director: After this certificate if filled in by the funeral director, pa Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 Yes 25 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Lo 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending Investigation 1 Netural 1 Yes 2 No 2 Accident Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C completely filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) and manner as stated.

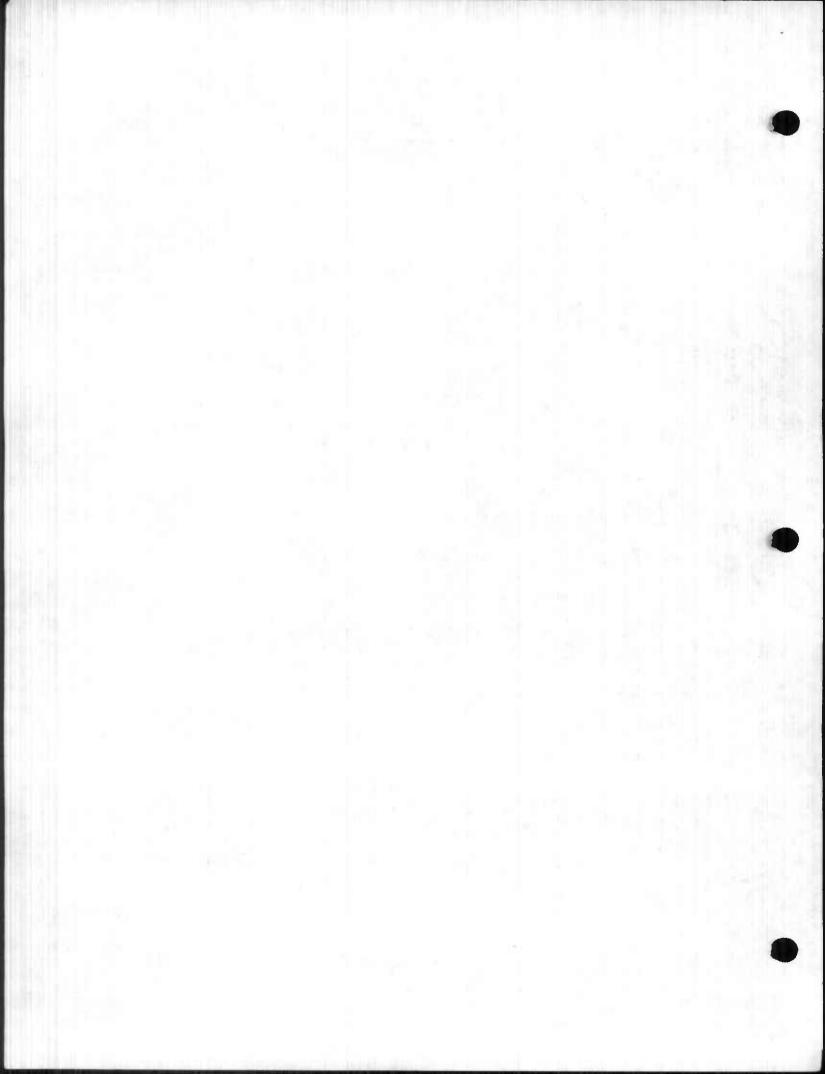
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29e Certifier edical end menner steted. 29b. Signeture englittle of certifier 29d. Date signed (Month, Dev. Year) 29c. License number 0 KES-000 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) BALTIMORE, MD HOPKINS HOSPITAL ohns 600 WOLFEST. Maissa

Registrar

State

Dete filed (Month, Dey, Year)

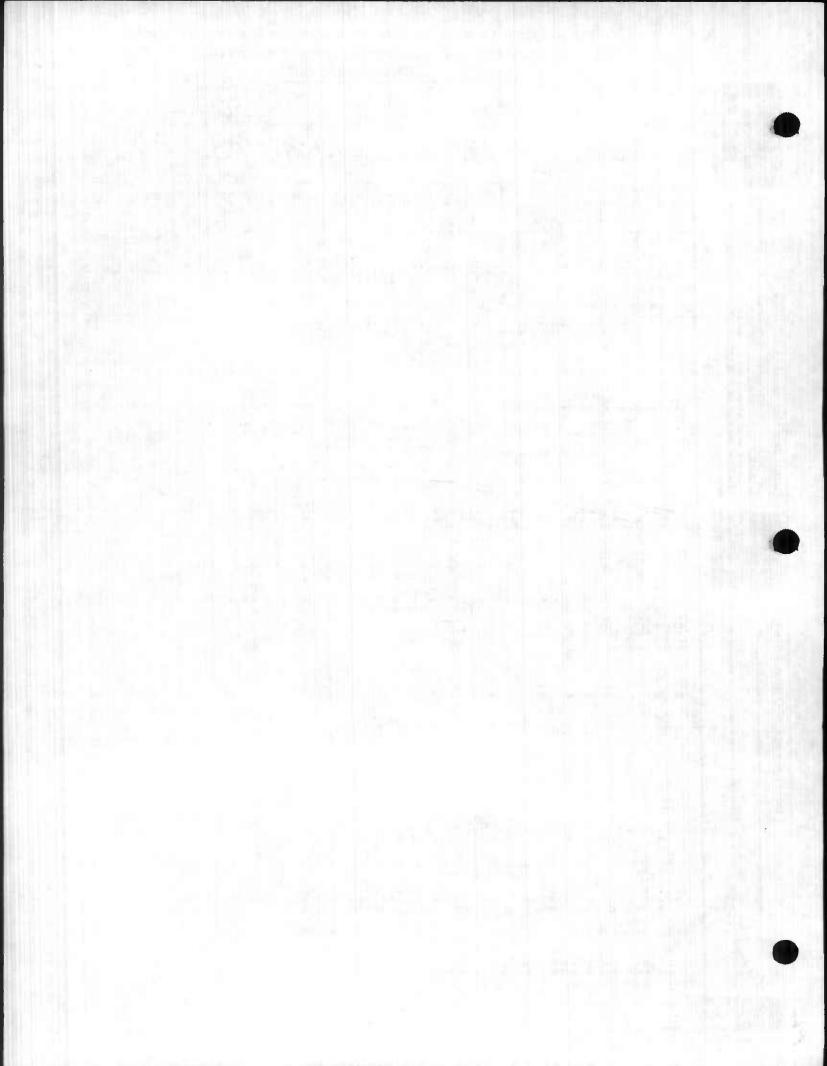
32. Registrar's-Signeture



State of Maryland / Department of Health and Mental Hygiene 00 290

	1. Decedent'a Neme	(First, Middle, Last	1					2. Date of I Month	Dey	Yeer	3. Tima of Deat
Physician /Medical		Lee	Buton						mer 10	00	1200
Examiner	4e Facility Name (If I	not institution, give	street and number	)			4b. City, Town,	or Location of De	afh 4c. Co	unty of Deat	
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uneral rector	5. Social Security Nu. 219–10–2.	445	x 7. A	ge (În yrs. le		Under 1 Year onths Deys	Hours A	Ain. (Month,	Birth Dey, Year) 4/25	9. Birt Co MAR	thpleca (State or Fore buntry) RYLAND
	Usual Residence of D	Decedenf 10b. County		10c. City.	Town or Location	on.			-,		10d. Inside City Lin
28a-f ahow outhed ector	MD	BALTIMOR	F		GELEIGH						1 □ Yes 2 💢
recto	10e. Street and Numi			IXLL		Of. Zip Code			10g. Citizer	n of What Co	ountry?
r flome 23a or 284-fa for ment be notified Funeral Director	8662 OAK	DOAD				2123	1			USA	
uner	11. Meritel Stefus	NOAD	12. Wes Deceden	Ever in U.S	. 13. Wes			? (Specify Yes or i	No- 14.	Raca - Ame	erican Indien,
leted by Fur	1 Never Merrier 3 Widowed 4		Armed Forces  1 Yes 2 If Yes, Give Yeer or Detes:	No	10	s, specify Cubi Yes 2 <b>X</b> No		иело нісал, етс.)		Black, Whit	e, ec. HITE
P P		15. Decedent's Edu	cation	*****	16a Decedent'	s Usuel Occup	ation		16b. Kind	of Business/	
To Be Completed	(Specify	y only highest grad	le completed) College (1-4or	(,3	(Give kind life. DO N	of work done IOT use retired	during most of	working			
omp	10TH GRAD		College (1-40)	3+)	CRAIN	OPERAT	OR		EAST	ERN ST	EEL
Be	17. Fether's Neme (F						18. Mother's	Nema (First, Midd	lle, Maiden Su	тете)	
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To	19a. Informent's Ner	me/Reletionship (T)	rpe, Print)		19b. Meiling A	ddress (Street	and Number o	r Rural Route Nur	nber, Cify or T	own, Stete, 2	Zip Code)
	ANNA BURTY	ON	W	IFE	8662 C	AK ROA	D BALT	IMORE, M	D 212	34	
	20e. Method of Dispo			CO	ace of Disposition	n (Neme of ry or other ple	ce)	Dete	20c. Local	tion - City or	Town, Stete
		Cremetion 3 F Other (Specify)		9	AIR MEM.			9/14/00	BELA:	IR, MD	
Al 20s 20s 21	21. Signeture of Fun	eral Service Licens	00		22. Na	me end Addre	ss of Fecility				
Buce	1	, _	-					RAL HOME			
	23a Part1. Enter the shock, or heert	diseese, or comp	lications that cause	ed the deeth.	Do not enter th	e mode of dyir	RAVEN ng, such es car	BLVD. T	OWSON.	MD 2	Approximate
ian	shock, or heert	failure. List only o	ne cause on eech	line.							Onset and Death
cal	Immediate Cause (F	inel		Sa	115						00000
er	disease or condition resulting in deeth)		ė	Duatoro	es a consequen	on od):					OTE Week
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EX	Sequentially list conditions, leading to immodule cause. Enter Under Cause (Disease or in	nediete lying									5 years
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	resulting will deathly Co					10111.4					15 yo.
	resulting will deathly La		d	1/19	peraj 1	Mellita	V.				15 year;
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	Pert II. Other elgnific			buf not resul	ting in the under	tying cause giv	ven in Pert I.		id tobecco us		
	Pert II. Other elgnific			buf not resul	ting in the under	tying cause giv	ven in Pert I.				to the cause of de
	Pert II. Other elgnific			buf not resul	ting in the under	tying cause giv	ven in Pert I.	1 24e. W		No 3 4	robably 4 Unkr
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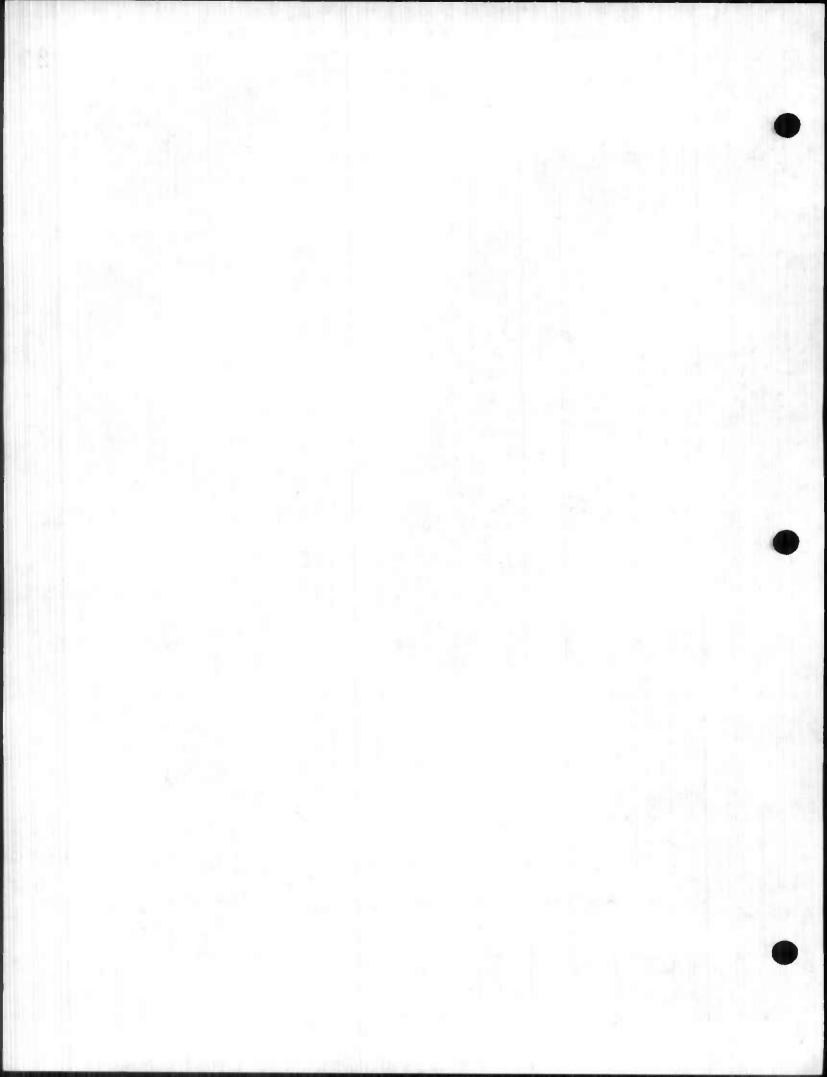


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

29020

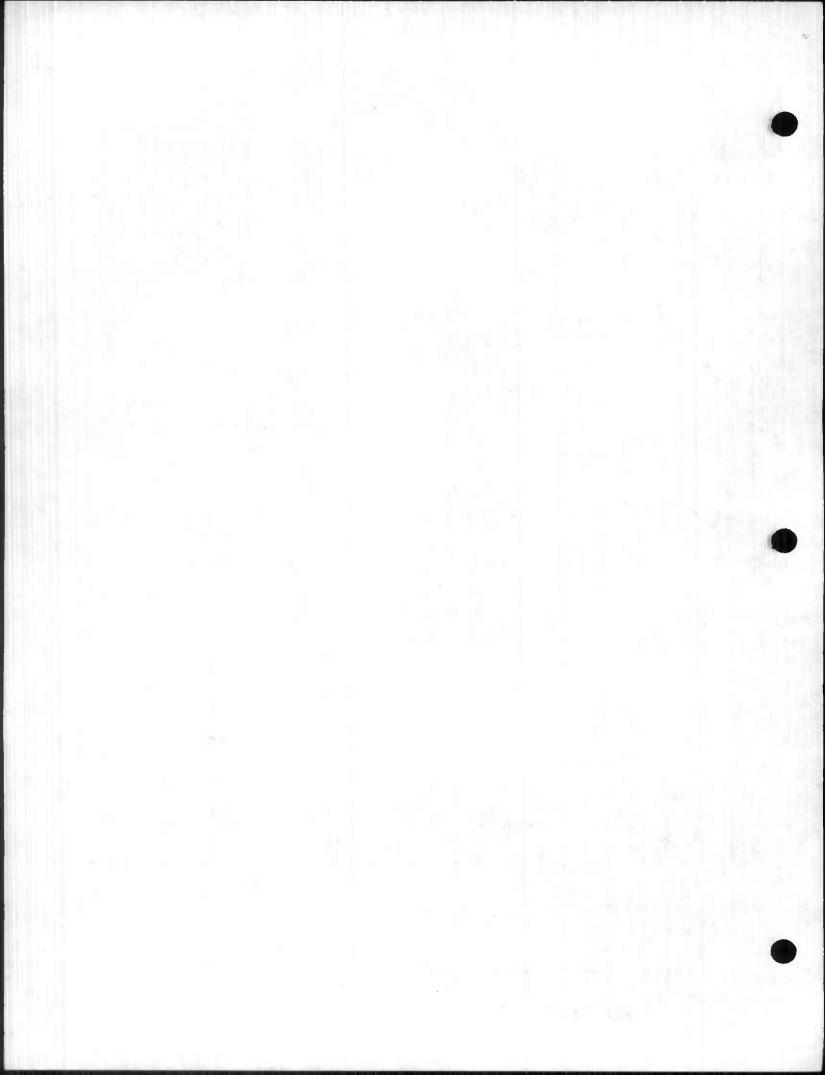
			Ce	runcate c	or Dealin	1		Reg. No.		
Physician /Medical	1. Decedent's Name (First, Middle, Las Margaret Florence		Betz				2. Data of De Month Septemb	Day	Yaar 2000	3. Tima of Death 7:00 a.m
Examiner	4a Facility Nama (If not institution, giva				4b. City, To	own, or Loca	ation of Death			
	Ivy Hall Geriatric				Middle			Balt:		
Funeral Director	5. Social Security Number 6. Sec. 212–01–4152	7. Aga (In ☐ M 2/☐√F 8.	yrs. last birthday) 9 Yrs.	If Under 1 You Months Da	ear If Under lys Hours	Min.	8. Date of Bir (Month, Da July 1	th ly, Year) 1911	9. Birthp Coun Mary	iace (State or Fore itry) Land
	Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Lo	ocation					1	0d. inside City Lim
28a-f sho notified at rector			Essex	, outroit						1 □ Yas 2√2
or 28a-fa be notified Director	10e. Street and Number			10f. Zip Cod	ie			10g. Citizen of	What Cour	itry?
	116 Back River Nec	k Road		212				U.S.A.		
or items 234 uniner must y Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Giva		Was Decedent If Yes, specify (  1 ☐ Yes 2 □  2 □			elfy Yes or No lican, etc.)		ce - Americ ick, White,	etc.
d by	32Widowed 4 □ Divorced	Yaar or Dates:							Whit	
t, the Medical	15. Decedent's Edu (Specify only highest grad	ucation da completed)	18a. Dece	dent's Usual Oc kind of work do DO NOT use re	ccupation one during mos	st of working	9	16b, Kind of E	Jusiness/Inc	dustry
a du	Elementery/Secondery (0-12)	College (1-4or 5+)	Secre		in <del>o</del> oj			Dual Co		
A O	17. Fathar's Nama (First, Middle, Last)		Secre	Lary	18. Moth	ner's Name (	(First, Middle,	Fuel Co		Y
c ever	John T. Deems				Anna	a You	ing			
-	19a. Intermant's Name/Relationship (T	ype, Print)	19b. Meili	ng Address (St	reet and Numb	ber or Rural	Route Numb	er, City or Town	, State, Zip	Code)
5	Anna Lewis (Ni	ece)	R.R.	1 Box	x 1138	Mt.	Unio	n, PA.	170	66
de .	20a. Method of Disposition	20	Ob. Plece of Dispo		1		Dete	20c. Location		
6	1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,		GreenMou			0/	13/200	n Palti	mora	Maryla
를 H	21. Signature of Funeral Service License			2. Name and Ac		lity	13/200	U Ball	more,	Maryia
188	Var							Home,		
	23a. Part I Poter the diseasa, or comp	lications that caused the	death. Do not en	er the mode of	dying, such es	s cardiec or	respiretory a	rest,	Mary.	Approximate the three and Between
iding physician and use as the burial-transit	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last	b. SEIZL	to (or as a consec	DISO R	156	E A SE E A SE				
for use		0								
by the tached	Part II. Other significant conditions co	ntributing to death but no	t resulting in the u	inderlying cause	e given in Part	11.				the cause of debely 412 Unkr
page 2 should be de Completed by F				0.0	10		24a. Was	an autopsy ormed?	av	ere autopsy tindin ailable prior to impletion of cause
hes b									ot	death?
rector, page							10	Yas 2 No	1(	Yes 212 No
Be G	25. Was case referred to medical axaminer?	Hospital:			Other		(Check only			
	1 Tes 20 No		2 ER/Outpatie					dence 6 Ot		(y)
tion the	27. Menner of Deeth  1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work?					28d. Describe how injury occurred			
completely filled in by the Medical Certifical	3 Suicide 6 Could not be determined	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)								
completely filled in by	29e. Certifier (Check only one)  W Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as and manner as and due to the cause (s) and due to the cause (s									
Me de	29b. Signature and title of certifier			29c. Lie	cense number			29d. Date sign	ed (Month,	Day, Year)
- 8	Sa in day	k July	MI	5	1271	ec.		911	2-10	10
1					4/1	0 8		1/	-10	
10	30. Name and eddress of person who con Dr. Savinder Ju				more !	Marvila	and 211	222		
0 01	31. Date tiled (Month, Dey, Year)	32. Registrar's		, balti	wore, I	ricit À 10	MIM 212			
State egistrar	055 4 4	100 Sens	va B	100	aks					
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State of Maryland / Department of Health and Mental Hygiene 00 29021

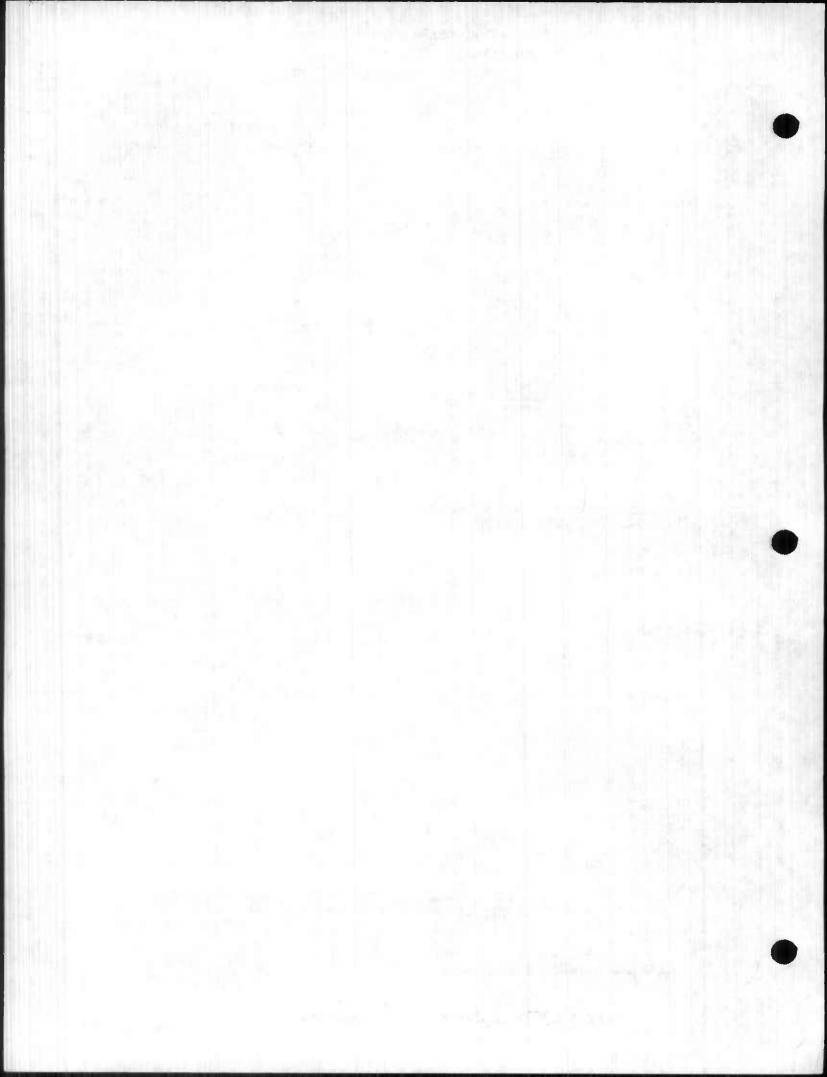
											Reg. No.		
	1. Decedent's Name (F	irst, Middle, Li	est)							2. Date of De Month	ath Dey	Year	3. Tima of Deatl
ician dical	THON	IAS			(	CRIST			- 1	EPTEMB		2000	20:19
niner	4a Facility Name (If no	t institution, gi	ve street and nu	mber)			4	b. City, To	wn, or Lo	cation of Deat		ty of Death	
	THE JOH	HNS HOP	KINS HO	SPITAL			E	BALTIN	MORE	CITY	N	/A	
al	5. Social Security Number	ber 6.	Sex 10 M 2□ F	7. Age (In y	rs. last birthdey	) If Under Months	1 Year Devs	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, De	th V Year)	9. Birth	placa (Stata or Fore
r	216-16-524	1	14∆M 2□F	76	Yrs.	WOTHING	Doys	Hours	14141.	May 10,	1924	000	WV
-	Usuat Residence of De												
		b.County Baltimo	ro	10c.	City, Town or L	ocation imore							10d. Inside City Lim
Director	111111111111111111111111111111111111111	Jarcino	16		Dalt	THIOTE							1 Yas 200
10	10a. Street and Numbe	r	-1131			101. Zip	Code				10g. Citizen o	What Cou	ntry?
	707 Maide	n Choi	ce Lane	#8T01				21228	3			USA	
Funeral	11. Merital Status		12. Was Dec	edent Ever in	U,S. 13.	Was Deced				ecity Yes or No Rican, etc.)	- 14. R	ace - Ameri	
2	1 Never Married	2X Married	Armed For 1 X Yes If Yes, Gi				**			Hican, etc.)		eck, White,	, etc.
-	3 ☐ Widowed 4 ☐	Divorced	If Yes, Gi	ve Detes: 147	-48	1□ Yes	2LTNo	Specify:			Spec	,	hite
	15.	. Decedent's E	ducation		16a. Dece	edent's Usue	el Occup	etion			16b. Kind of		
Compieso	(Specify of Elementary) Seconda		ade completed)		(Give	DO NOT us	rk done d se retired	during mos d)	it of work	ing			
5	Elementary Seconda	ry (0-12)	College (	1-Aor 5+)		mai	nage	r			pos	t off:	ice
	17. Father's Name (Firs	st, Middle, Lasi	)	97500				18. Mothe	er's Nem	e (First, Middle	, Maiden Surna	ame)	J. 17 1 5
	John A. (	Christ								Ira H.	Smi+h		
0	19a. Informent's Neme		(Type Print)		19b Mail	ing Address	Street	end Numb		el Route Numb		n Stete Zi	p Code)
	Dorothy Ch												
	20a. Method of Disposi		pouse	201	. Place of Disp		_	oice	Lane	#8T01	Balti:		
	1 Burial 2 C		Removal from		cemetery, cre	matory or o	ther plea	ce)	1	Date	200. Location	1 - Oity Oi 1	Own, Olalo
	4 Donetion 5		* *						1				
	21. Signeture of Funeral	al Service Lica	Wan Sa	nd:	2	2. Name en State	Ana	ss of Facili	Boar	d 655	W. Ral	timor	e Street
	Bound	14 4	5 1					_			We Day	CIMOL	c Derece
1	Baltimore, MD 21201												
-	Baltimore, MD 21201  23a Part Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.												Approximata
	23a. Part Enter the d shock, or heart ta	liseese, of con ilure. List only	polications that of one ceuse on	caused the de each line.	eath. Do not er						rrest,	1	Approximata Interval Between Onset end Deeth
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The second secon	shock, or heart ta	ilure. List only	a.	EXSANG	UINATIO	N equence of):	le ol dyin	ng, such as			rrest,		Interval Between Onset end Deeth  FOUR HOUF WENTY-FIV
Control of the Contro	shock, or heart to immediate Cause (Findisease or condition resulting in death)	ilure. List only	a.	EXSANG  Due to	UINATIO O (or es e conse	N equence of):	SEAS	ng, such as			rrest,	T	Interval Between Onset end Deeth FOUR HOUR WENTY-FIV YEARS
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Registrar



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	Examine		ta Facility Name (1 Howard Co	ounty	Genero	el Ho	spital			Columbia	ı	Hou	vard	
	Funeral Director		5. Social Security N 560 – 21 – 21	124	6. Sex 1 ☐ M	2⊠ F	7. Age (In yrs. 85	. lest birthdey) Yrs.	If Under 1 Yeer Months Days	If Under 24 Hrs. Hours Min.	8. Date of Si (Month, Di Nov. (	13 1914	9. Birthp Coun Kore	lace (State or Foreign try) A
	yland Now Mi	- 1-	Usual Residence of 10a. Stete	f Decedent 10b. Count	у		10c. C	ity, Town or Lo	cation				1	0d. Inside City Limits
	for the seal of	101	MD	How	ard			Columbi	a					1 ☐ Yes 2 💢 No
	or 28a-f	Directo	10e. Street and Nur						10f. Zip Code			10g. Citizen of W	hat Cour	itry?
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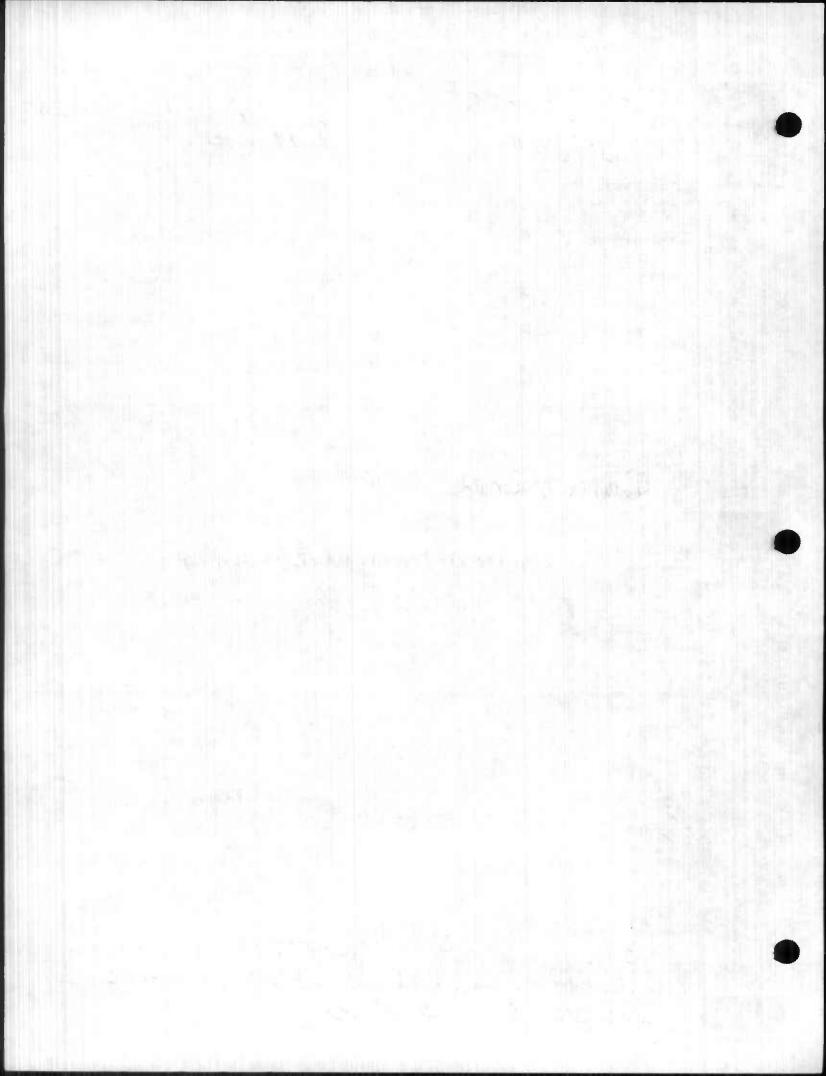


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

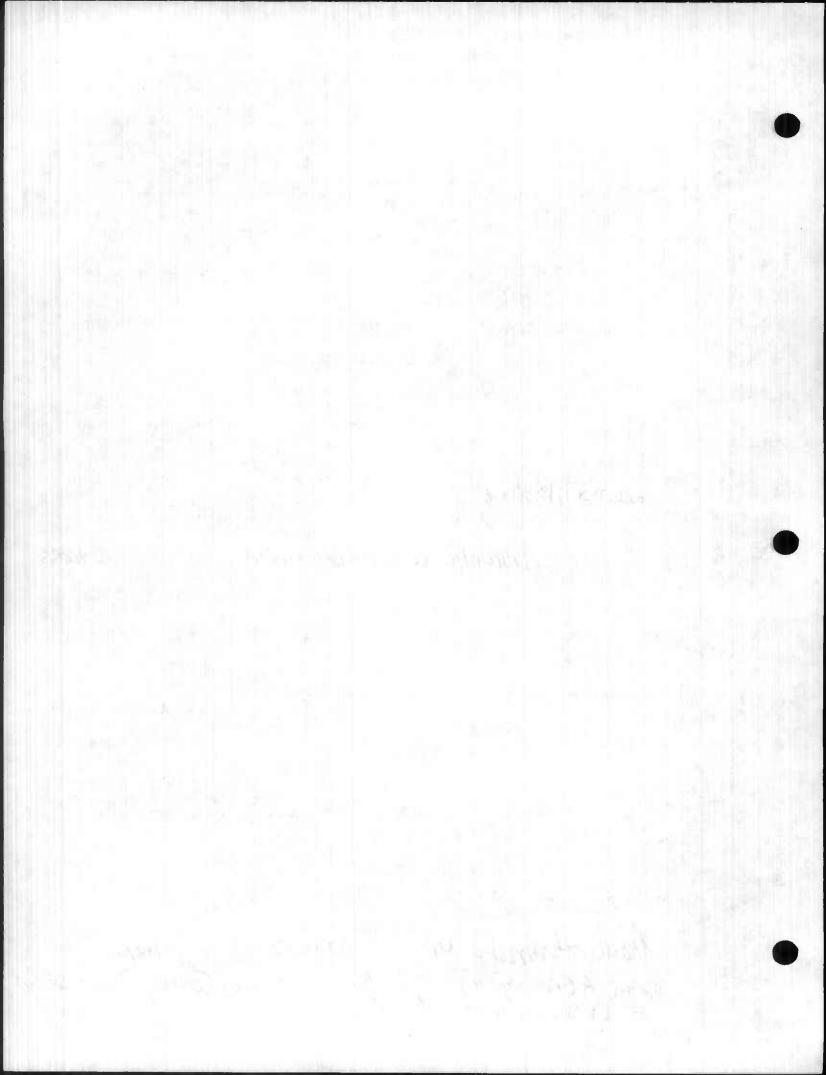
29023

	Certificate of Death	Reg. No.	29023
Physician	1. Decedent's Name (Frst, Middle, Last)	2. Date of Death Month Day Yes	3. Tima of Death
/Medica	1 Mul CVOSS	September 11,200	
Examine	(1) + 1) · · · · · · · · · · · · · · · · · ·	of Location of Death 4c. County of D	eath
Formula	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 If		Birthplece (Steta or Foreign
Funeral Director	212-30-0782 1 M 20 F 67 Yrs. Months Days Hours N	fin. (Month, Day, Year)	aryland
2	Usual Rasidence of Decedant  10a. State 10b. County 10c. City, Town or Location		10d. Insida City Limits
a Maryla hart sho diffied at	Nowaland N/A		1 X Yas 2 □ No
death with the Mar riss 23s or 28s-f at rinust be notified		10g. Citizen of What	A
- 3 #40 17	3 ☐ Widowed 4 ☒ Divorced Year or Detes:	uarto Rican, etc.) Bleck, W	merican Indien, Ihite, atc. Black
1 21215-0 ed within 72 ho ygiene. wr than 'naturn it, the Medical.	15. Decedent's Education (Specify only highest grede completed) (Give kind of work done during most of life. DO NOT use retired)	working 16b. Kind of Busina	ss/Industry
121 121 men. Den.	Elemantary/Secondary (0-12) Collega (1-4or 5+) Waitress	Restaura	nt
d 2 d d 2		Name (First, Middle, Maidan Surnema)	
yland build be fil Mental H mrhed oth affic ever	Arnett Washington	Margaret Young	
Maryland 21215-0020 and 2 should be filed within 72 hours at alth and Mental Hygiere.  27 is marked other than "natural", or a traumatic event, the Medical Exam.	19a. Informant's Name/Relationship (Type, Print) Audie Cross/son  19b. Mailing Addrass (Street and Number of 1301 St. Paul Street)		
altimore, mit. Pages 1 a partment of Hea portent. If them y Injury or othe	20a. Mathod of Disposition  1	Date 20c. Location - City 9/12/00 Baltimor	
Balt permit. Departr imports any inji	21. Signatur of Funda Segrico-licers of David Cremations of Society 299 Frederick Ro	ty of Maryland, Incoad Baltimore, MD	21228
	23a. Part1. Enter the disaese, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line.	diac or raspiratory arrast,	Approximata intarval Batween
Physician /Medical			Onset and Deeth
Examiner	Immediata Ceuse (Finel diseasa or condition resulting in death)  a Squarmh cell (artinoma at to	le esuphagns	19400
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ficate be a physician is the buring	that initiated events resulting In death) Last  Dua to (or as a consequence of):		
Du Du Du			
death ce attendi		and Did to become use a contrib	under the the server of death 2
O the state of	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contrib	Probably 4 Unknown
- 5 60		~~~	
Cord		24e. Was en autopsy performed?	tb. Ware autopsy findings available prior to complation of cause of death?
The la		1 ☐ Yes 2 PNo	1□ Yas 21 No
f Vital Recognitions to the law secreticate has director, page 2		Death (Check only one)	
The second of the	Pospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursin	ng Home 5 Rasidance 6 Other (S	Specify)
After th funeral	27. Manner of Death 28a. Dete of Injury 28b. Tima of Injury 28c. Injury at Work? 28c. Injury at Work?	28d. Describe how injury occurred	
Division or Attending after death. Director: After din by the fune	2 Accident Investigation M 1 Yes 2 No 3 Suicida 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office	28f. Location (Street and Number of	r Rurel Route Number.
Division of the or Attending P as after death.  al Director: After the funer led in by the funer Certification:	determined  4 Homlcide  determined  286. Placa of Injury - At nome, term, street, factory, office building, etc. (Specify)	City or Town, State)	
Division To the Hospital or Attending I within 24 hours after death. To the Funeral Director: Attention Completely filled in by the funeral Medical Certification			
of the of		29d. Pata signed (M	lonth, Day, Year)
FSFO	1 / MD N00437	42 Contenher	1,2000
N.N	30. Name and address of person who completed cause of death (Item 23a) (Type Print)	LSE Billimore, V	11/ 212 12
UND		180 mire, 1	17 91701
State Registrar	OFF 1 / 2000 /2000 /2 / / / / / / / /		



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61	. Social Security Number	6. Sex		Age (In yrs. I 38		Months	er 1 Year s Deys	Hours	Min.	8. Date of Bi (Month, D FEB 1]	ey, Year)			place (State or Fore
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10	William B	Brown	Corrig	gan				M	onica	a Mary	Ash			
1 7	19a. Intormant's Name/Relationsh	hip (Type, I	Print)		19b. Maili	ing Addre	ss (Street	end Numb	er or Run	al Route Numi	ber, City o	or Town,	Stete, Zip	Code)
T	Karen L. Corrig	ran/rri	fo		8700	Sto	neho	ise D	rive	E1110	ort	City	, MD	21043
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death
Month
Dey
SETEMBER-08-2000 **Physician** LUKE DOLES. 7:11 Am /Medical 4c. County of Death
BALTIMORE 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RAMPALLSTOWN NORTHWEST HOSPITAL LENTER If Under 24 Hrs. Hours Min. 6. Dete of Birth (Month, Dey, Year) OCT 2 1916 If Under 1 Year
Months Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 10 M 2□ F Hours Days 83 Yrs. Director Usual Residence of Decede the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at t Nes 2 No RAWDALLSTOWN Funeral Director BATIMORE 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Neme: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Emerican page. Bleck, White, etc. 1 Never Married 2 Merried 21215-0020 1 Yes 2 No Snecity: Specify: BLHCK Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STEEL HILL STEELWORK Baitimore, Maryland 17. Father's Name (First, Middle, Last) 16. Mother's Name (Firşt, Middle, Maiden Sumeme) UNKNOWN UNKNOWN 19b. Meiting Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2/204 19a. Informant's Neme/Relationship (Type, Print) BALTO W. MicHAEL 606 TOWNSON HO ROOM 20% 20b. Place of Disposition (Name of cemetery, cremetory or other) 20a. Method of Disposition

Buriat 2 Cremation 3 Removet from State 20c. Location - City or Town, Stete Donation 5 Other (Specify) 21. Signature of Euneral Service Line 22. Name and Address of Facility 70 23a. Part1. Enter the disease, or complications that caused the difatt. Do not enter the mode of dying, such as cardiac shock, or heart failure. Lattonly one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final SEPSIS disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) USB signed by the atter Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown OBSTRUCTIVE PULMONARY 31803119 CHRONIC Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? has X No this certificate 1 Yes 200 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Nnpatient 2 EP/Outpatient 3 DOA 27. Manner of Death To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the luneral uneral 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier (Check only one) 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29c. License number

1) 4 27 2 3 29b. Signature and little of certifier

State Registrar

31. Date filed (Month, Day, Year) SEP 1 4 2000

VYERAHALLI

HARISH 32. Registrar's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTHWEST

arr

PANDALLSTOWN Oaks

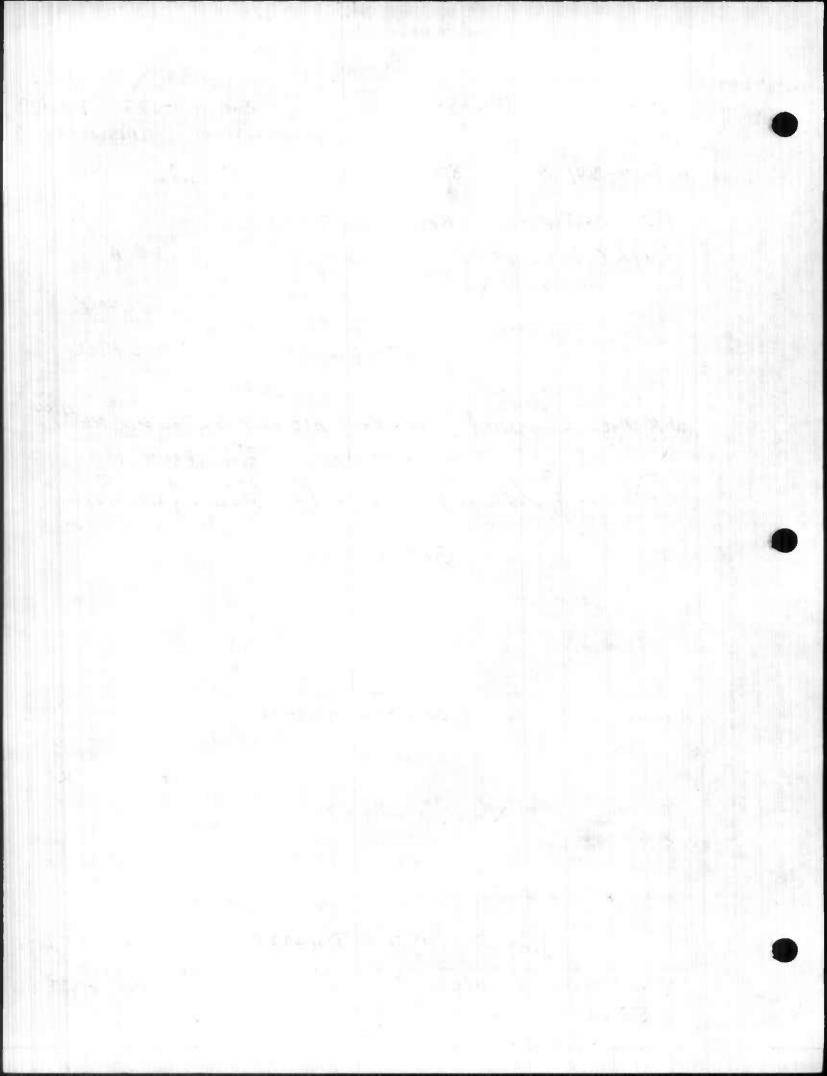
= 2000

SEPTEMBER - 08

MD

CENTER.

21133



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Day September 1/ Year 5:50 AM Janet McCreary Daum 2000 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Catonsville Baltimore Charlestown Care Center If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Devs Months 1□M 2♥F 99 Yrs. July, 22, 1901 Maryland 214-12-8000 Usual Residence of Dece 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Catonsville 1 ☐ Yes 🏋 ☐ No Maryland Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 707 Maiden Choice Lane 21228 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11 Marital Status Bleck, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No Specify: SpecifWhite 3 Notion 3 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Government 17. Father's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 417 Unknown George McCreary 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Margaret Milleker- neice 124 Rosewood Avenue, Catonsville, Maryland21228 20a. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) September Baltimore Cemetery 14,2000 Baltimore, Maryland 22. Nama and Addrass of Facility Witzke Funeral Home, Inc. 21. Signature of Funerel Service Licenses 1630 Edmondson Avenue, Catonsville, Maryland21228 23a. Part. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart fellure. List only one cause on each line. Approximate Interval Between Onset and Deeth Hemolytic Anemia Immediate Cause (Finel 4 minths disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Dua to (or as e consequence of): that initieted events resulting in death) Last Due to (or es e consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yea 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 Yes 2 No 1 Yes 2 PNo 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20No 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 DeNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office bullding, etc. (Specify) 4 Homicide

Box 68760. Records, P.O. Vital ō Division in 24 hours after death.
The Funeral Director: After the furnishing the furnishin

Jane

To the Hosp within 24 ho To the Fune completely fi

**DHMH 16 Rev 6/95** 

Registrar

Physician

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

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72 hours after

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parmit. Pages I and 2 should be filled wit Department of Health and Mental Hygiens Important: If them 27 is marked other the any injury or other treatments event, the 1 page.

Physician

/Medical

Examiner

attending physician and for use as the burla-transit

Examiner

Physician/Medical

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After Attending

Certification: To

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Saitimore, Maryland 21215-0020

31. Dete filed (Month, Day, Year) 1 4 2000

60

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Lock MO 32. Registrer's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

majde Choice Lone 21228

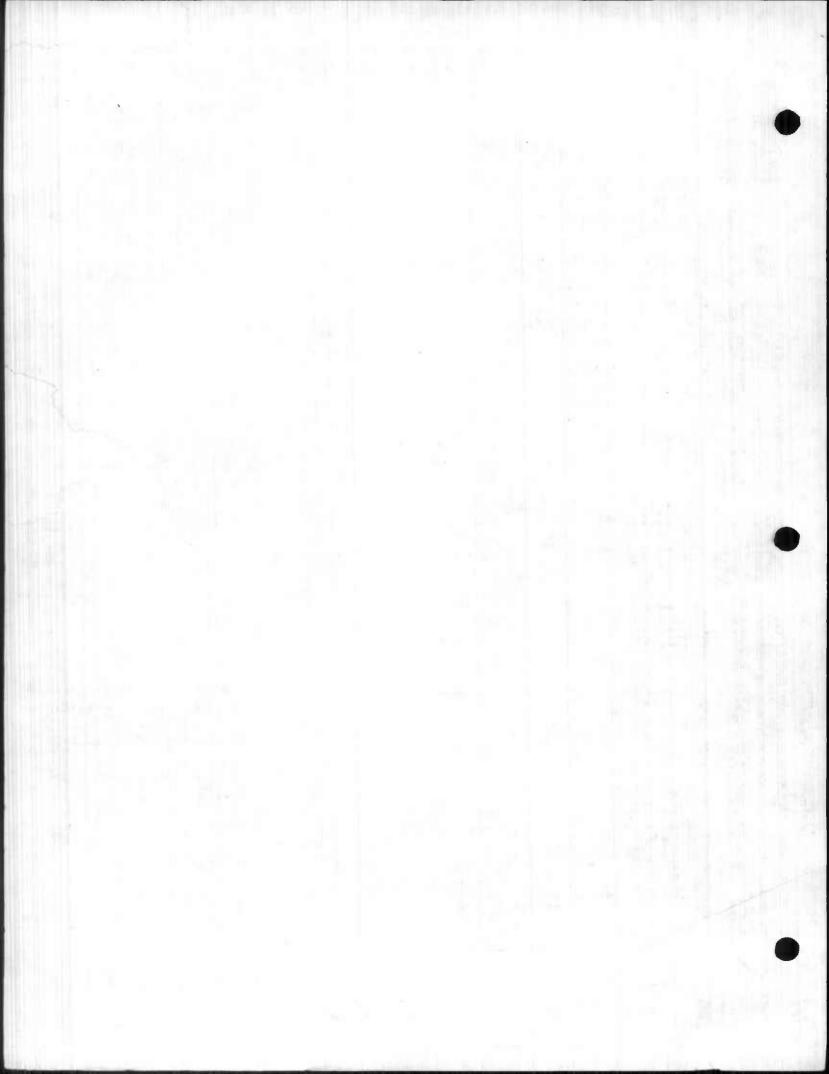
12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

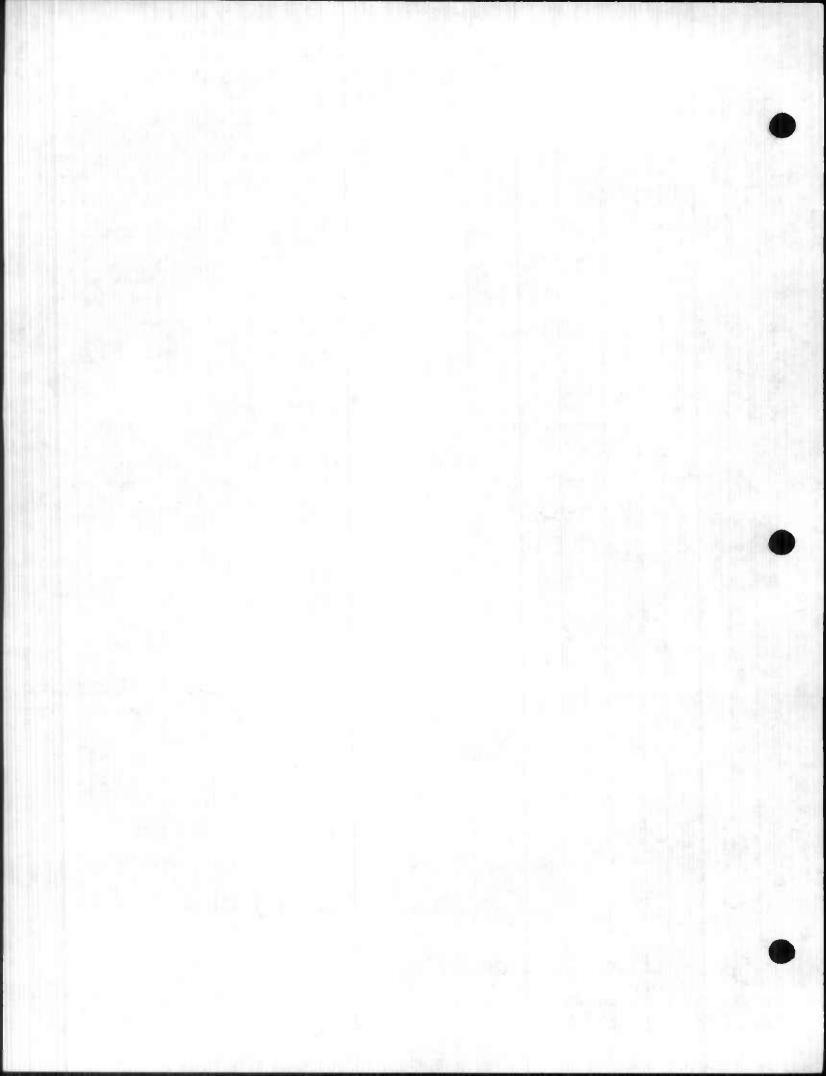
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29d. Dete signed (Month, Day, Year)

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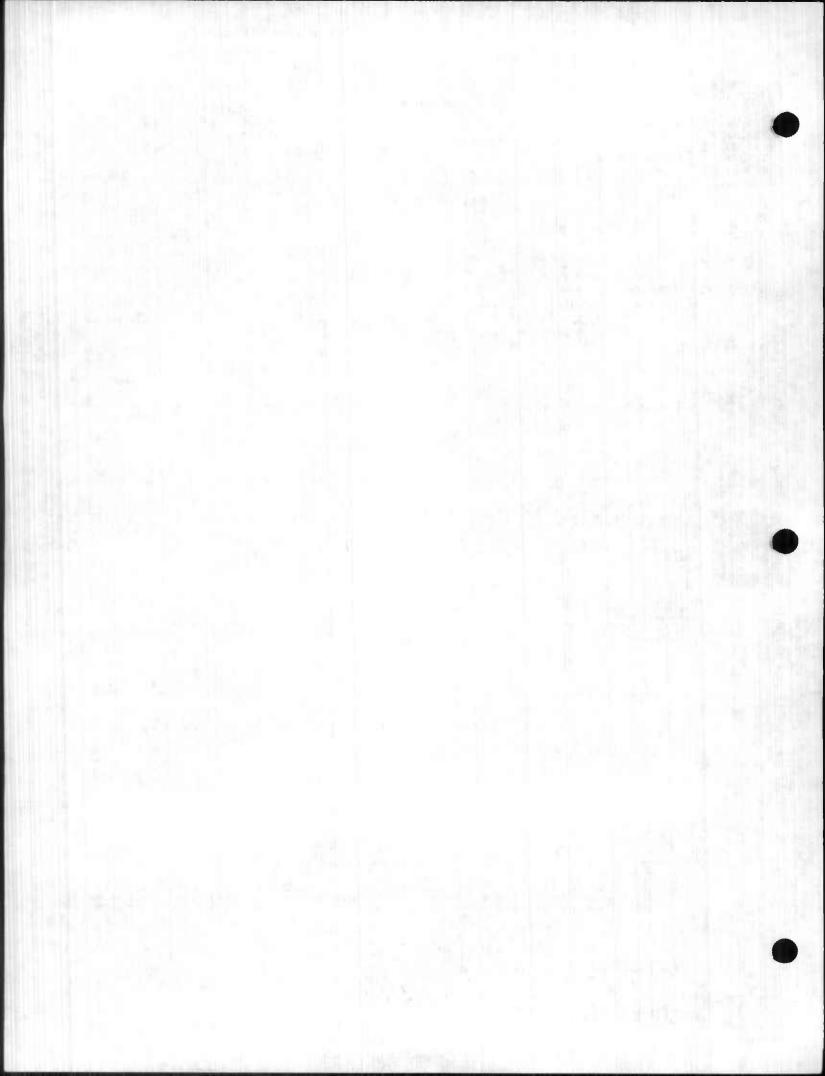


	o, Last)	06	runoato or	Death	2. Date of Deat			3. Time of Death
EVELYN 3	TRENE D	ETZEL			Month	Dey	Yeer	12.50 AM
4a Facility Name (If not institution				4b. City, Town, or L		4c. County		
		NTER		BALTIMO		N/		
5. Social Security Number 220–18–8038	6. Sex 7. Age	(In yrs. last birthday Yrs.	Months Days		8. Dete of Birth (Month, Day,	Year)	9. Birthplac	e (Stete or Foreign
Usuel Residence of Decedeni		74			May 31	1926		Md.
10a. State 10b. County		10c. City, Town or L	ocation				10d.	Inside City Limits
Md. Balt:	imore	Baltim	ore				110	1 ☐ Yes 2 ☑ No
10e. Street and Number	BERTHEY'S		10f. Zip Code		1	0g. Citizen of W	/hat Country	?
3283 Ryerson	Circle		212	27		U.S.		
11. Marital Status 1 ☐ Never Married 2 ☑ Marri	12. Wes Decedent E Armed Forces? 1 ☐ Yes 2010 If Yes, Give		. Wes Decedent of If Yes, specify Cul 1 ☐ Yes 2 ② No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Bleci	- American k, White, etc : Whit	
3 Widowed 4 Divorced	Yeer or Detes:	140/0	1 1 10					
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Elementery/Secondary (0-12)	College (1-4or 5-	+)	tory Wo			Office	Supr	oly Mftr
17. Fether's Neme (First, Middle, I	Last)			18. Mother's Nan	ne (First, Middle, M			
John R. Young	g			Ida			(unkr	nown)
19e. Informent's Name/Reletionsh	nlp (Type, Print)	19b. Mai	ling Address (Stree	t end Number or Ru	rei Route Number	City or Town,	Stete, Zip Co	ode)
Willard Detze	el/husband			son Circ				
20a. Method of Disposition  1 X Burial 2 Cremation	3 □Removal from State	-	emetory or other pla			20c. Location -		
4 Donetion 5 Other (Sp	pecify)	Cedar H	ill Cem	etery	9/12	Baltim	ore,	Md.
Signature of Funerel Servica to 23a. Pert1. Enler the disease, or shock, or heeft feilure. List of the state of the shock or heeft feilure.	hura	ugle 4		chie Hwy		o. Md.	2122	25 pproximate iterval Between
Immediate Cause (Finel disease or condition resulting In deeth)		HOOGEK		MPHOMA	1		18	MONTILL
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c	Oue to (or es a conse						
Part II. Other algolificant condition		t not resulting in the	underlying cause o	iven In Pert t.	23b. Dld to	bacco usa cor	ntribute to th	ne cause of death?
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							10)	fes 2□ No
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25. Was case referred to medical exeminer?					1 - Ye			
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exeminer?  1 Yes 2 No  27. Menner of Death  1 Neturet 5 Pending investig  3 Suicide 6 Could n determi  29a. Certifier Check only 2 Medical 8	1 Mg Inpatier 28e. Date of Injunior beined 28e. Place of Injunior beined 28e. Place of Injunior building, etc. 28e. Place of Injunior building, etc. 28e. Place of Injunior building, etc.	y Year) 28b. Time Injury  ry - At home, ferm, s (Specify)  f my knowledge, desexamination and/or i	of 28c. Injury M 1[ street, fectory, office	ther: 4 Nursing H ury et ork? Yes 2 No	th (Check only on ome 5 Reside 28d. Describe he 28f. Location (St. City or Town, end due to the co.	ence 6 Other ow injury occurret and Number, State)	er (Specify) red er or Rural F	ed.
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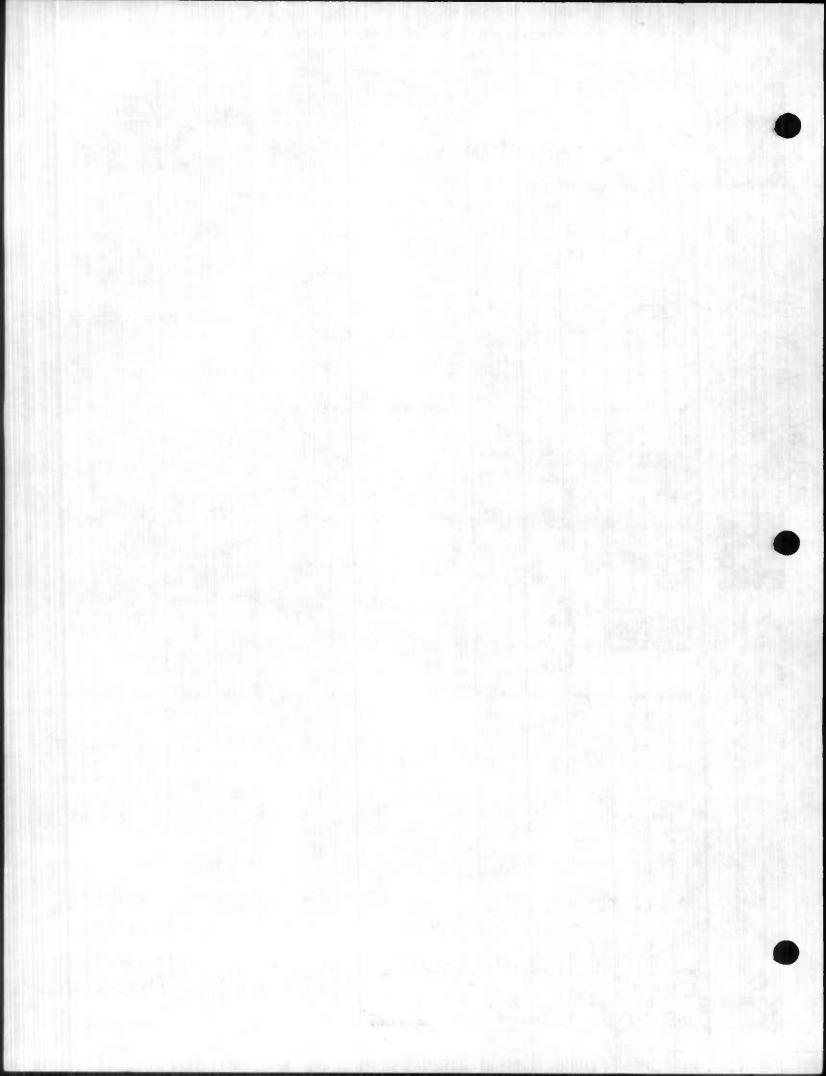
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Ebbie William Donahue 12,2000 September 1:10 p.m. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Genesis Eldercare Hamilton Center If Under 1 Year | If Undar 24 Hrs. | 8. Data of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F Birthplaca (Steta or Foreign Country) **Funeral** Months 80 251-07-1434 July 18, 1920 South Carolina **Director** Usual Residence of Decedent with the Manfand 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director 284-11 South Carolina Darlington Hartsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: if item 27 is marked other than "--- any injury or other traument." 5 29550 United States 527 Morrison Road 234 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No It Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: specify: White þ 3 N Widowed 4 □ Divorced Year or Datas: WWII Completed 16a Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede com Elementery/Secondary (0-12) College (1-4or 5+) Carpenter Construction 8 18. Mothar's Name (First, Middle, Maiden Sumema) 17. Father's Name (First, Middle, Last) Bessie Hodges John Donahue 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) 19a. intoment's Name/Relationship (Type, Print) Hartsville, SC 527 Morrison Road Dolly Donahue / Daughter 20b. Piaca of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stata 20a. Method of Disposition 1 D Burial 2 Cremation 3 Removal from Stata 9/14/00 4 Donation 5 Other (Specify) Florence, SC National Cemetery 21. Signeture of Funeral Service Licensee Michael E. Canapp 22. Name and Address of Fecility 5305 Harford Road 21214 Baltimore, MD Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Daath Physician PUS /Medical immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last as the burial-tran Due to (or es a consequence of): Box 68760, Due to (or as e consequenca ot) USA P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No Records, Certification: To Be Completed by 24b. Were autopsy tindings evailable prior to 24a. Was an autopsy performed? completion of cause of death? certificate has 2 2 No 1 Yes 2 No of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 41 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Division 5 Pending investigation within 24 hours after death.
To the Funeral Director: Al 1 Yes 2 No 2 Accident 28t. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Piaca of Injury - At home, term, street, tactory, offica building, etc. (Specify) 4 | Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. Medical 29e. Certifier 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) 94 29b. Signature and titla of cartitia 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23al) (Type, Print) Lery 507 32, Bagistrar's Sollature 31. Date tiled (Month, Dey, Yeer) SEP 1 4 2000 State Registrar



sician		ecedent's Name (First, Middle, Las Lou Ella DeBloi					2. Date of De	Day O	2000 3.T	ima of Death
edical miner	4a F	acility Name (If not institution, give			- (	Ab City, Town, o	Location of Deat		of Death	101,
11111101	1	2. 11. 6	are Hospita	al Cente	-	Mosed	ale	Ba	Himor	e
ral tor				yrs. last birthday) 62 Yrs.	If Under Months		s. 8. Date of Bir	2, 1938	9. Birthplece (S Country) WestVirg	State or Foreig
		State 10b. County	10	c. City, Town or Lo	cation				10d Ins	side City Limits
Į,			I/A	Baltimor					- 11	Yes 2 No
Directo	10e.	Street and Number	7.1	Daleamor	10f. Zip	Code		10g. Citizen of V	What Country?	
		23 N. Luzerne Av	re		212	205		United	States	
Funeral	11.1	Marital Status	12. Was Decedent Ever Armed Forces?	in U,S. 13. \	Vas Deced	lent of Hispanic Origin? ( cify Cuban, Mexican, Pue	Specify Yes or No	o- 14. Rac	e - American Ind	lan,
Dy F		□ Never Married 2  Married	1 Yes 2 No		☐ Yes 2			Specify		
		3 ☐ Widowed 4 ☒ Divorced	Year or Dates:	16a Dagge	not's Heus	1 Occupation		16h Kind of Br	usiness/Industry	
Completed	-	15. Decedent's Ed (Specify only highest gre	de completed)	(Give	kind of wor	Occupetion     done during most of was retired)	orking	100. Kind of bi	Dell'i ess/ilidustry	
	E	emantery/Secondery (0-12)	College (1-4or 5+)	Hou	sewi	fe		Domes	tic	
	17. F	Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle iche E. Jef	, Meiden Suman	ne)	
		Oklahoma S	Short, Sr.			(Unk	nown)	Jeffrey		
		. Informant's Name/Relationship (1				(Street end Number or I				)
		Loretta McElveen		2510 Ob. Place of Dispo		th Point Rd	T	nore, MD		
		Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐	Removal from State	cemetery, cren	netory or o	ther plece)	Date O /4/2 /00		City or Town, St	
	1700	4 ☐ Donation 5 ☐ Other (Specify Signature of Funeral Service Lion		Chesapeake	-		9/13/00	Beltsv	ille, M	)
	21-1	A-10 F	77			d Address of Fecility Stephen D 1	ohrmann	РΔ		
_	220	Part Enter the disagra or com	plications that caused the	death Do not ant	717	Stephen D. 1 Green Pastu	res Dr.,	Towson,	MD 2128	B6 eximete
	200	Part1. Enter the disease, or comp shock, or heart failure. List only	one cause on each line.	death. Do not ent	er trie mou	e or dying, such as card	ac or respiretory e	inest,	Interv	ral Between
	Imm	nediate Causa (Final	0	1001	C	2.2.2				
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Examiner				( )						
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by Phy							24a. Was	s an autopsy omed?	24b. Were eu evailable	prior to
8 - 8								70.00	of death	on of cause
							1)30	Yes 2□No	1 XYes	2 No
		Was case referred to medical	Hospital:			Othor	eath (Check only			
Be Completed by	25. \	examiner?	Hospital: 1 Inpatient	2 ER/Outpatien			Home 5 Res	how injury occur		
to postulation of	25. \	examiner? I ☐ Yes ②X No			м	Bc. Injury at Work? 1 ☐ Yes 2 ☐ No	200. 5000.100	non injury coop.		
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lo be completed by	25. V	examiner? I Yes 2 No  Manner of Death Natural 5 Pending Investigation	28e. Date of Injury (Month, Dey Ye	At home, farm, str	eet, factory	, office		wn, Stete)		
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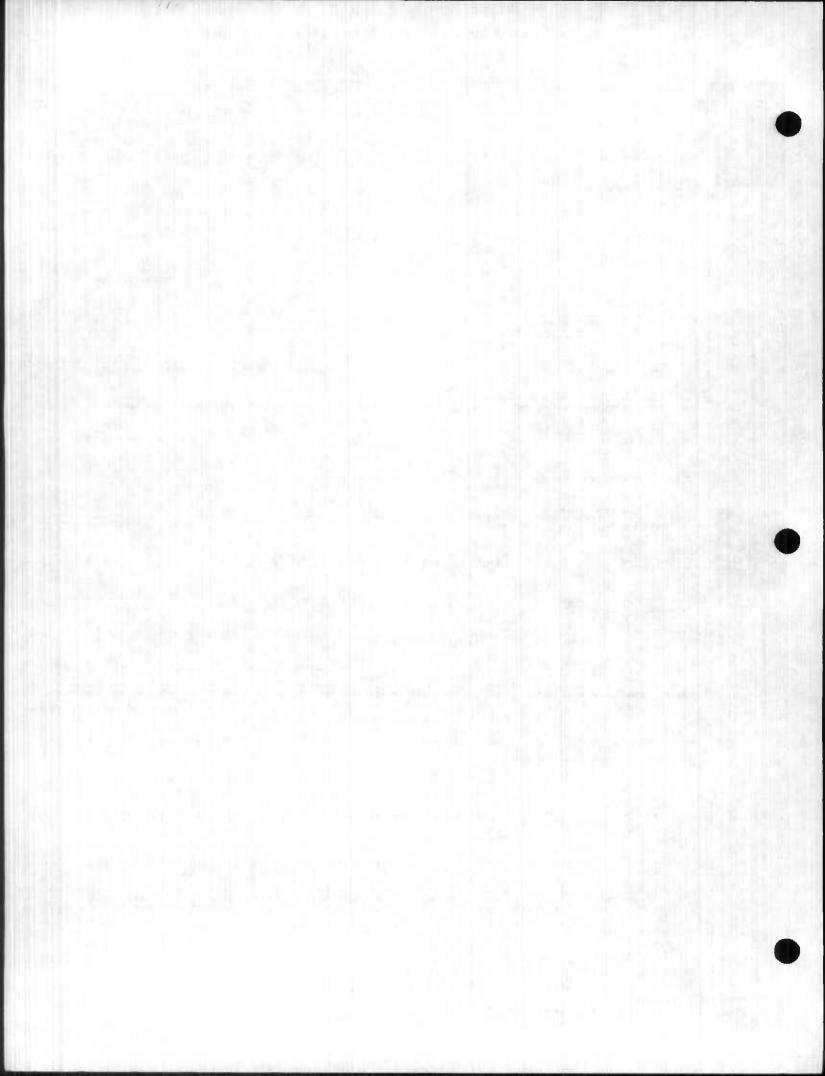
State of Maryland / Department of Health and Mental Hygiene

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29030

			Ce	rtificate	of Deatl	n	Re	g. No.		
	1. Decedent's Name (First, Middle, Las	st)					2. Date of Death	Day	Year	3. Time of Death
Physician	Isaac Thomas En	alish. Ir.					Sept		-000	23:45
/Medical	4a Facility Name (If not institution, give				4b. City, 1	Town, or Lo	cation of Death	4c. County		
Examiner					Pa	eltimo	4.0		altin	naka
	Gilchrist Center  5. Sociel Security Number 6. S.		yrs. lest birthday)	If Under 1 Y						
uneral		Mar all a	yrs. <i>iest birthoay)</i> Yrs.		ays Hours	Min.	8. Date of Birth (Month, Dey.	Year)	9. Birthp	iace (State or Forei
ector	210-20-0272	73	110.				Aug. 14,	1927	1	narycana
	Usuel Residence of Decedent  10a. Stete 10b. County	10	c. City, Town or Lo	ocation					1	0d. Inside City Limi
1	Toa. Stele	10								1X Yes 2 N
8	Maryland N/A		Balt	imore						NU 162 2UI
Dire	10e. Street and Number		- 1.0/1 py	10f. Zip Co	de		10	10g. Citizen of What Country?		
	2611 Kentucky Ave	NIIO			21213		u. s			1.
918	11. Meritel Stetus	12. Was Decedent Ever	rin U.S. 13.	Was Decedent		Origin? (Spe	cify Yes or No-		e - Americ	
Funeral	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 □ No		If Yes, specify	Cuban, Mexic	an, Puerto	ecify Yes or No- Rican, etc.)	Blac	ck, White,	etc.
À	3 Widowed 4 Divorced	IT Yes, GIVE	1.17.7	1 ☐ Yes 2 💢	No Specif	fy:		Specify	r: tota	ite
P			WII							
ete	15. Decedent's Ed (Specify only highest gra-		18a. Dece	dent's Usuai O kind of work a DO NOT use n	ccupation lone during mo	ost of worki	ng	16b. Kind of Bi	usiness/Inc	dustry
de	Elementary/Secondary (0-12)	College (1-4or 5+)	life.							
Comp		1 Year		Clerk	2			Ra	ilro	ad
Be	17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Sumame)					
0	Isaac T. English,	Sr.				Mar	y Ethel	Hughes		
-	19a. Informant's Name/Relationship (7		19b. Maili	na Address (S	treet and Num	ber or Rure	I Route Number	City or Town.	Stete. Zip	Code)
	Carol R. English		2011 20b. Place of Disponentery, cre			mue,	Baltimo	20c. Location -		
C 2	1 Burial 2 Cremetion 3	Removation State	r place)		Date	20C. LOCATION -	City or 10	wii, State		
	4 Donation 5 Other (Specify		Green Mo	unt Cre	ematory	1 19	/12/00	Baltim	ore.	Maryland
4	21. Signature of Seneral Service Licen						lome Inc			
9	1 /3 X /									04040
	Man I for						altimor		jalna	
	23a Part 1. Enter the disputer or companies abook, or heart failure. List only	plications that coused the one cause on each line.	death. Do not en	ter tha mode o	dying, such a	as cardiac c	or respiratory arre	est,	1	Approximate Interval Between
ian	/								1	Onset end Deeth
cal	Immediata Cause (Final disease or condition	Non	small	mll	can	COE				u ears
ner	resulting in death)		to (or as a conse							9 44.3
e l		500	, to (or as a conso	querios ory.						
Examiner		b	4. (						1	
×	Sequentially list conditions, if any, leading to immediate	Due	to (or as a conse	quence oi):						
edical Examir	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury	C							1	
edicai	that initiated events resulting in death) Last	Due	to (or as a consec	quence of):						
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		d.		7712-11					1	
leted by Physician	Pert II. Other significant conditions of	ontributing to death but no	ot resulting In the u	inderlying caus	e given in Par	rt I.	23b. Did to	bacco uae co	ntribute to	the cause of deal
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4	congest	ive hear	+ faili	ere			1	20110	00110	SESTY 4 GOTTAIN
l by	Q						24a. Was a	n autoneu	24h W	ere autopsy finding
Completed							perform	ned?	av	ailable prior to mpletion of cause
0.						7-1-1	THE REAL PROPERTY.		of	death?
0							1 🗆 Ye	s ZONO	10	∃Yes 2□ No
Be	25. Was case referred to medical				26. Pla	ce of Death	n (Check only on	e)		
To Be Com	examiner?	Hospital:	2 ER/Outpatie	nt 3 DOA	Other		ma 5 Reside		ner (Specif	y hospic
400	27. Manner of Death	, , , , , , , , , , , , , , , , , , , ,					28d. Describe ho		_	y) ( · ·
0	Natural 5 Pending	28a. Date of Injury (Month, Day Ye	ear) Injury	м 200.	Injury at Work?			in injury coop.		
Certification:	2 Accident Investigation 3 Sulcide 6 Could not be						00/ 1/ /0/			10-4-41-4-
=======================================	4 Homicide determined	28e. Place of Injury - building, etc. (S	· At home, farm, st Specify)	reet, factory, of	ffice		City or Town	reet and Numi i, State)	oer or Huri	al Route Number,
Ö										
8	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and							ace, and due to the cause(s) and mannar as stated.		
edical	(Check only 2 Medical Examone)	niner: On the basis of exa and manner stated		vestigation, in	the time, date and place, and due to the cause(s) and mannar as stated.  In my opinion, death occurred at the time, date and place, and due to the cause(s)			o the cause(s)		
¥.	29b. Signature and title of certifie	) ^		29c. L	29c. License number 29d. Dete signed (Month, Dey, Year)					
	MINI	(d) 11	D	1	500 5	192		Sept		
	yeu m	laste "		1				ZP!	1	
	30. Name and address of person who o	completed cause of death	(Item 23a) (Type,	Print) PP	E \$20	3				
	Helen M Gorda	1 6565N	Charles	st. 8	altimo	No M	ND 212	04		
State	31. Dete filed (Month, Dey, Year)	32. Registrer's		1	-					
State	SED 1 / 20	100 \ \	· 19	100	- V.					

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Deta of Deeth 1. Decedent's Name (First, Middle, Last) Day **Physician** Month Year 4b. City, Town, or Location of Death 4c. County of Death Joseph Field 11:30 am /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner care carter adousville Baltimore harlestown If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Linder 1 Yaar 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1⊠M 2□ F 89 Director 212-05 -3985 May 3, 1911 New York Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location show r 28a-f show 10d. Inside City Limits 1 Yes 2 No Director Maryland Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or 21045 5037 Netherstone Court USA Funeral Was Decedent of Hispanic Origin? (Specify Yas or Notif Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🖾 No Specify: White Specify: þ If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrical Techician Utility Department of Health and Mental Hygie Important: if Item 27 is marked other tany Injury or other traumatic event, to once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Joseph Field Mabe1 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Janet Zerhusen - Daughter 5055 Drywell Court, Columbia, Maryland, 21045 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) September Baltimore-WashingtonCrem. 14,2000 Laurel, Maryland 21. Signature of Funaral Service Licensee 22. Name and Address of Facility Witzke Funeral Home, Inc. 5555 Twin Knolls Road, Columbia, Maryland 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Tutra Craneal Bleed disaasa or condition resulting In death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as e consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? been signed by the should be detached 1 Yea 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yas a No 1 Yes 2 No certificate Division of Vitai Name: Attending Physician: 25. Was case referred to medical examinar? Be 26. Place-of Deeth (Check only one) Other: 40 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending death. 1 Yes 2 No investigation hours after death 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Direcompletely filled in b 6 To the Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.

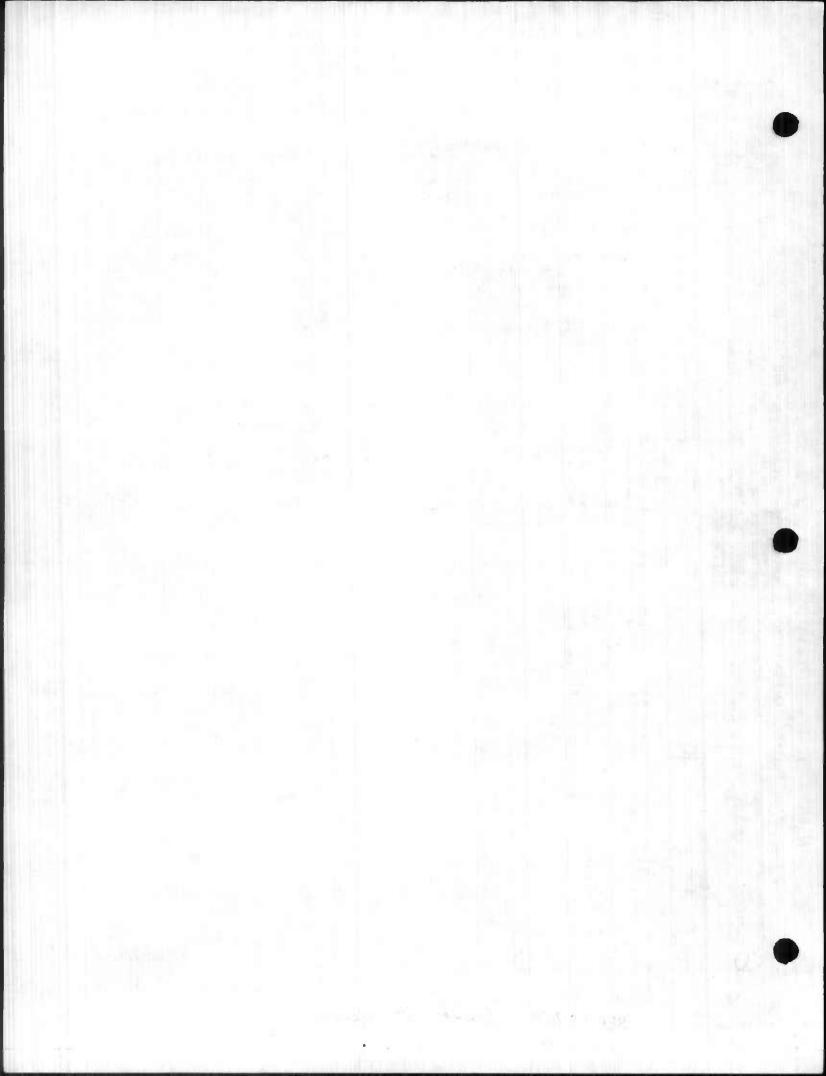
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steled. Medical 29a, Certifier 29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Lane, catoni, Mr, MD, 21228 Sa (920) Maiden Angres 31. Data filed (Month, Day, Year) 32. Registrar's Signature State

**DHMH 16 Rev 6/95** 

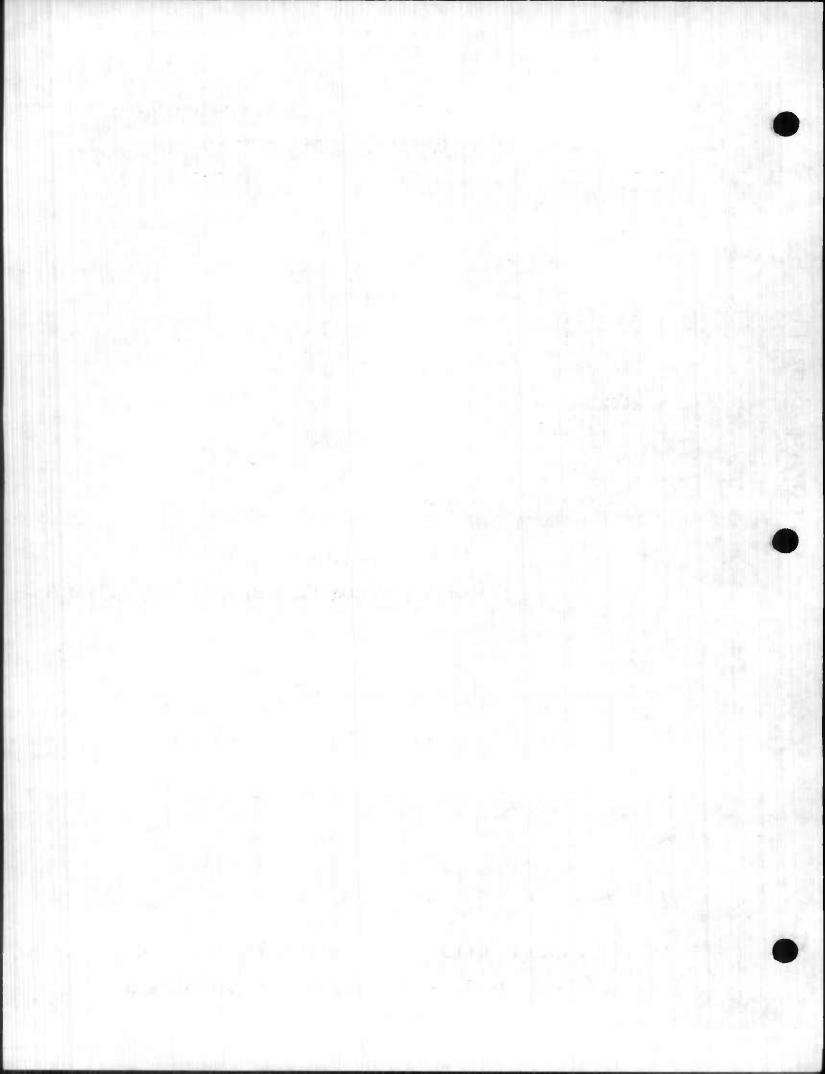
Registrar

SEP 13 2000

Joseph



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Nama (First Middle Last) 2. Data of Death 3. Time of Death **Physician** September 12,2000 8:15 pm Betty Meads Gregory /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not Institution, giva street and number) Examiner Baltmare 0-1 Sinai Hospital Battimore If Undar 1 Year | If Under 24 Hrs. Birthplace (Stata or Foreign Country)
 NA 5. Social Security Number Age (In yrs. last birthday) Months Days Hours 1 M 2 F 218-36-8841 62 Md Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes ANO Locheran Directo Norma 23a or 28a-1 Md Balto 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be 6806 Parsons Avenue 21207 S Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Yas 2 No If Yes, Give Year or Dates: 1 Never Married 2 XMarried 8 1 Ves 2 No Specity: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grada completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore City Elementery/Secondery (0-12) Cotlege (1-4or 5+) Schools 12th grade Masters Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Meads Lillian Lucus 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Important: if item 27 is any injury or other trai 2008. Donald D. Gregory - Husband 6806 Parsons Avenue Balto Co, Md 20a. Method of Disposition
10 Burial, 2 Cramation 3 Ramoval from Stata 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State Date Pages ment of Park 9-16-00 Arbutus, 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial 22. Name and Address of Facility
March F/H Wes 21. Signature of Funeral Service License West MUNUSIN 4300 Wabash Avenue Baltimore, Md 21215 ir tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, earl feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical immediate Quese (Final disease or condition resulting in deeth) Metastatic Cancer Examiner Due to (or as a consequenca of) Physician/Medical Examiner Primary Breast Cancer
Due to (or as a consequence of): 10 years The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and 68760 that initiated events resulting in death) Last Dua to (or as a consequence of) Box P.O. ata has been signed by the a page 2 should be detached Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yee 2 No 3 Probably Unknown Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificata has been 1 Yes 2 No of Vital Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Appatient 2 ER/Outpatient 3 DOA Certification: To 27. Magner of Death
Natural
2 Accident 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation spital or Attendin nours after death. neral Director: Aft y filled in by the fur 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28a. Placa of Injury - At home, farm, streat, factory, offica building, etc. (Specify) 4 Homicide To the Hospital within 24 hours To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) Medicai 29e. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifian 29c. License number September 12,2000 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) M.D onai 32. Registrer's Signeture 31. Date fited (Month, Dey, Year) Registrar



Please Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month SET 0,30 **Physician** 00 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Name (If not institution, give street and number) Examiner Mi DDLE BAUTIMOLE CO DRAL 7. Age (In yrs. last birthday) If Under 1 Yeer 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) curity Number 6. Sex **Funeral** 1 M 2 F Days 215-32-8952 Usual Residence of Decedent 65 Yrs. 15,1935 Director with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Funeral Director MD. 10g. Citizen of Whet Country? 10e. Street and Numbe 21220 death 14. Rece - American Indian, Black, White, etc. . Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) filed within 72 hours effer Yes 2 No 1 Yes, Give Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 20 No by 3 Widowed 4 Divorced WHITE Be Completed Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) and Mental I Pages 1 and 2 should be BAKRINGER 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) HD. 2/220 nt of Health GEONGE TR. BALTO. other Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of D 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Department of Important: If eny injury or pace. 21. Signature of Juneral Service Licensee 70. Romas 23a. Part1. Enter the disease of complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Physician/Medical Examiner usa as tha burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) 68760. the attending physician Due to (or es e consequence of) Box 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 No 3 Probably 4 ☐ Unknown been signed by by 8 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed

The law requires that the death certificate be executed Division of Vital Records. page 2 should this certificate has is or Attending Physicien: The safer death.

Si Director: After this certificated in by the funeral director, px Medical Certification: To

filled in by

To the Hospital of within 24 hours a To the Funeral D

1 Yes 2 No 27. Manner of Death

29a. Certifier

25. Was case referred to medical examiner?

5 Pending investigation Naturel 2 Accident 3 Suicide 6 Could not be 4 Homicide

Hospitel: 1 ☐ Inpatient

2 ER/Outpatient 3 DOA 28b. Time of

Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Other:

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

5 Residence 6 Other (Specify)

1 Yes

26. Place of Death (Check only one)

4 ☐ Nursing Home

Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Sig

29d. Date signed (Month, Day, Year)

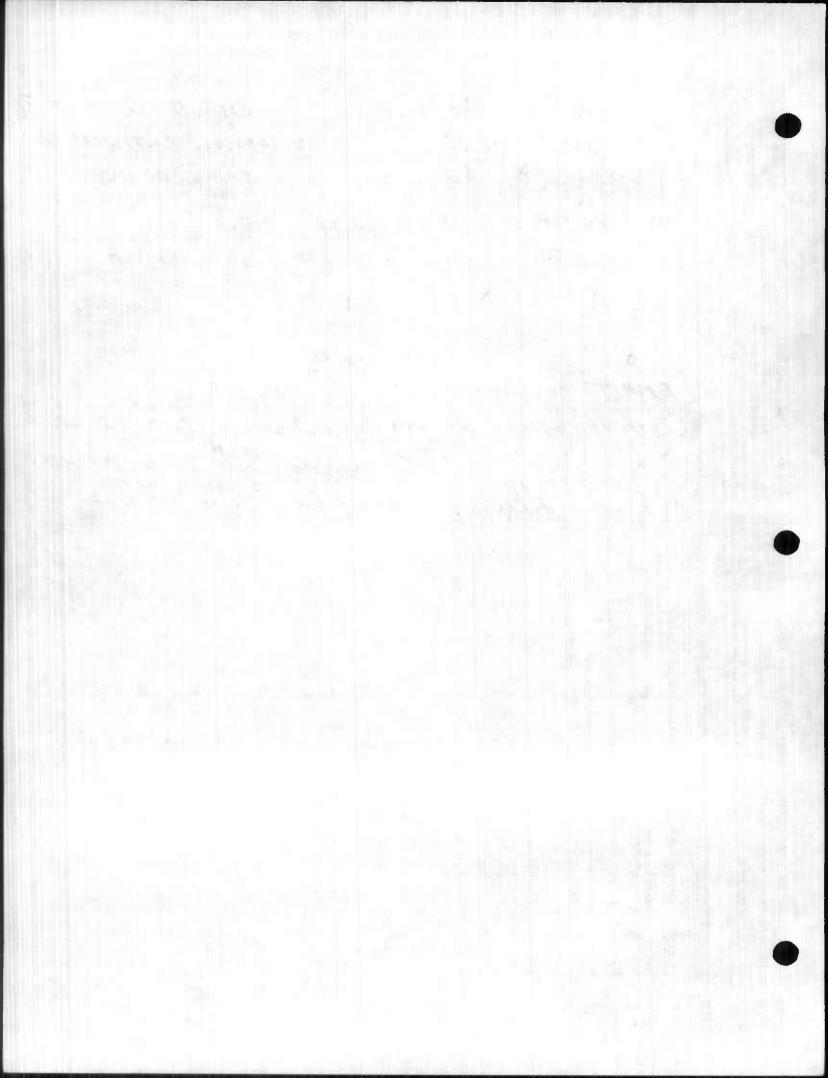
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31. Date filed (Month, Day, Year) 2000 SEP 4

**DHMH 16 Rev 6/95** 

State

Registrar

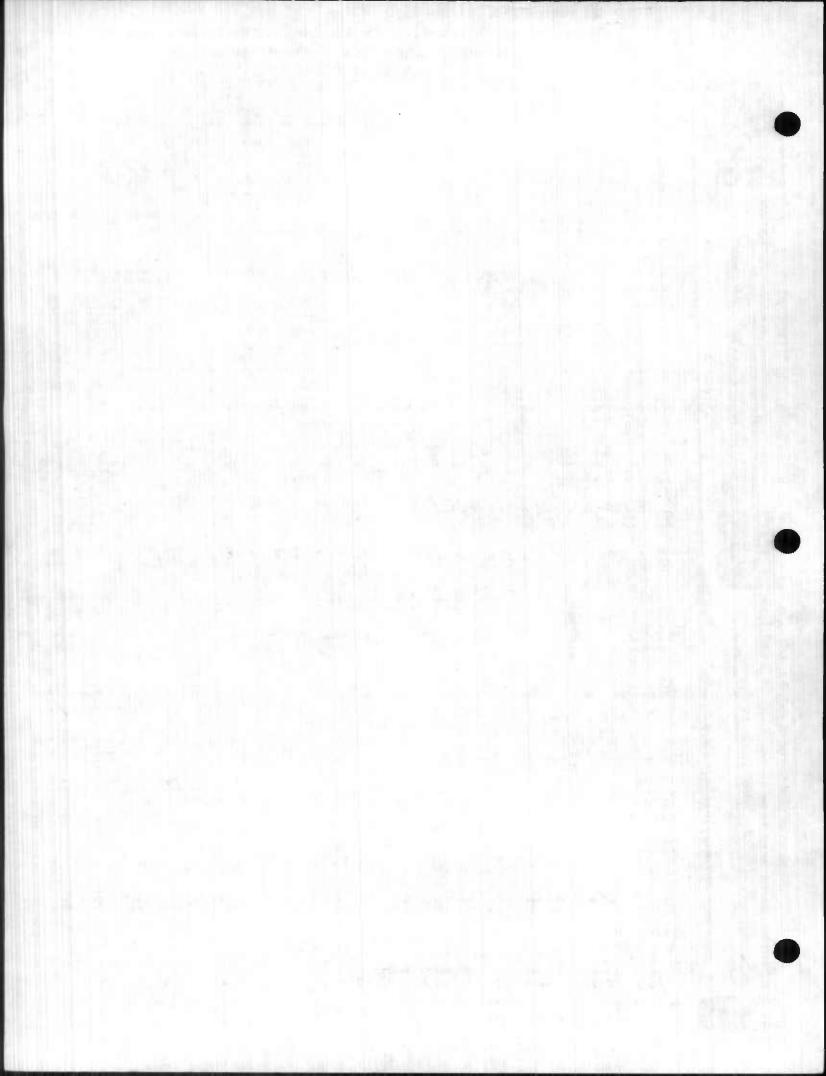


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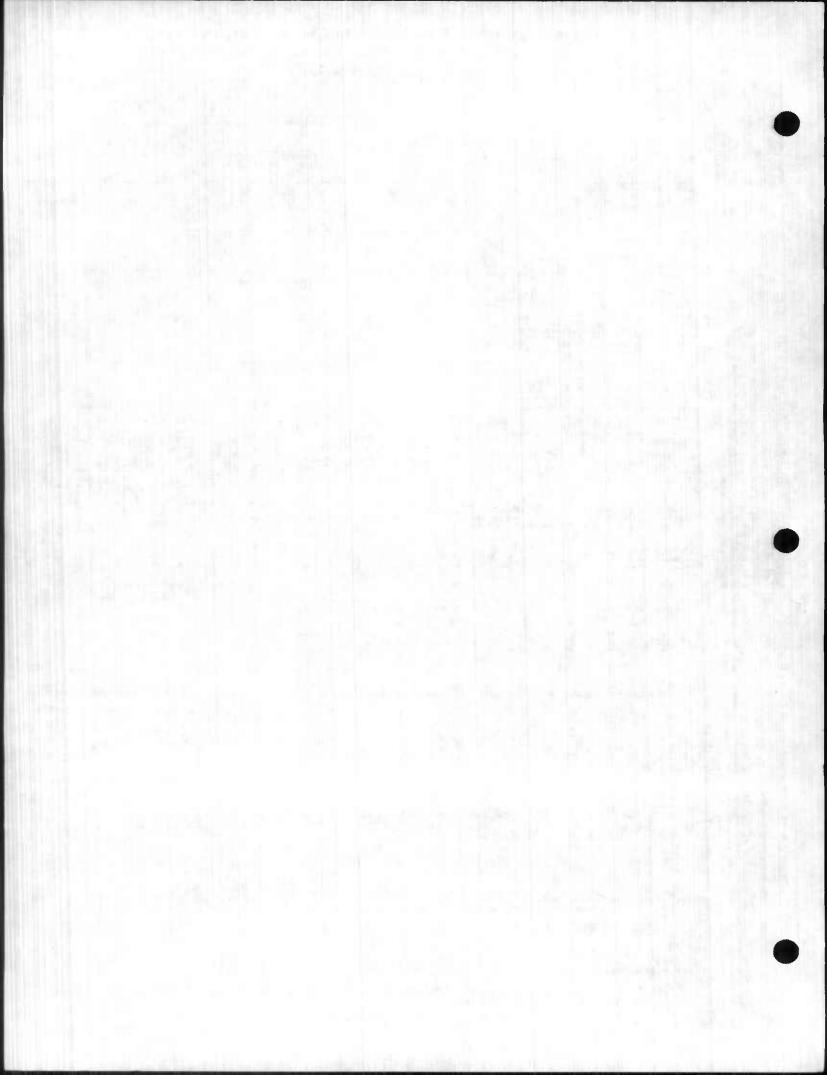
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Description of The Part of March Leaf   The State of Charles   The S								Cer	tifica	e of	Death			Reg. No.			
September 7 2000 3:00 A.M.			dent's Name (Fir	rst, Middle, La	st)								2. Dete of De	ath	Van	3. Time of Deat	h
## Facility the entitle of pass and reference of the pass of the p				Mary	Eliza	abeth G	ray									3.00 A	M
Provided Plant Section Company   April 1997   April 1997	V.	An Cont	ity Name (If not i	institution, giv	e street end n	number)					4b. City, To	wn, or Lo				J.VV A	al'le_
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The Company of the											If Under	24 Hrs. Min.	8. Dete of Birt (Month, De	h y, Year)	9. Birthp	lace (State or Fore	aign
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State	P. C. that the ned by the detach		DEMI	ENTI	+ .								10	Yes 2□ No	3□ Pro	bably 4 Unkr	nown
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29s. Certifler (Check only one)  29s. Certifler (Check only one)  29s. Certifler (Check only one)  29s. Signature and title of certifier  29s. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of deeth (Item 23s) (Type, Print)  TO CHURCH ST. BALTIMORE, M.D. 21225  State  31. Dete filed (Month, Day, Year)  32. Registrar's Signature	of the side	-	ner of Death		28a. Date of Injury (Month, Dey Year)  28b. Time of longury Injury Wor				y at rk?	2				(y)			
29s. Certifler (Check only one)  29s. Certifler (Check only one)  29s. Certifler (Check only one)  29s. Signature and title of certifier  29s. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of deeth (Item 23s) (Type, Print)  TO CHURCH ST. BALTIMORE, M.D. 21225  State  31. Dete filed (Month, Day, Year)  32. Registrar's Signature	Sicolar Hend Geath tor: The It	2 3		_		an of take A	hama fa				105 2 🗆	NO	29f Location /	Street and Num	har or Pur	al Doute Number	
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30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)  7/0 CffuRcit Si. BALTINORE, MD 2/225.  State  31. Dete filed (Month, Dey, Year)  32. Registrar's Signature  4. Aprinth	• Hospii 24 hour • Funen letely fill										d piace, th occur	and due to the red at the time,	cause(s) and m date end place	anner as a , and due to	tated. o the cause(s)		
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)  7/0 CffuRcit Si. BALTINORE, MD 2/225.  State  31. Dete filed (Month, Dey, Year)  32. Registrar's Signature  4. Aprinth	To th To th comp												29d. Date sign	ed (Month,	Day, Year)		
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State 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature 4 April 1	3	30. Nam				use of deeth (I	tem 23a)	(Type, I	Print)				21	225	,		
Registrar SEP 1 4 2000		10						4		loon	6						



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Ce	ertifica	te of	Death		Reg. No	D.		
	1. Decedent's Nama (First, Middla, Las						2. Data of Month		v Voor		na of Death
Physician /Medical	Susan Catherine	e Hicks					Sept	1	2000	0 11	1:30pm
Examiner	4a Facility Name (If not institution, give	street and number)				4b. City, Town	, or Location of De	eath 40	. County of Dea	ith	
	Manorcare Heal	th Service	s- Rid	ge R	d.	N/Z		F	Baltimo	ore	
Funeral Director	5. Social Security Number 6. S 219-26-2910 1	D When	yrs. last birthday 62 Yrs.	) If Under Months	Days		Min. (Month,	Birth Day, Year, 1/193		thptaca (Si ountry) entuc	ata or Foraign
,	Usual Rasidence of Decedant  10a. Stata 10b. County	100	. City, Town or L	agation						10d Incid	do City Limite
23s or 23s-f show ust be notified at rai Director	Md. Baltime		. City, Town of L	N/A							da City Limits Yas 2X No
at be notified to be notified if Director	10e. Street and Number 578 Welbrook Ro	d.			p Code 1221				itizen of What C	ountry?	
Examiner must Examiner must by Funeral	11. Marital Status  1 Nevar Married 2/15/Married  3 Widowed 4 Divorced	12. Was Decedant Evar Armed Forcas? 1 ☐ Yas 2 ☑No If Yes, Give Yaar or Datas:	in U,S. 13.	Was Dece If Yas, ap	ecify Cubi	lispanic Originan, Maxican, I Specity:	n? (Specify Yas or Puarto Rican, atc.)	No-	14. Race - Am Black, Whi Specify: W	te, atc.	ın,
eted	15. Decedent'a Ed (Specify only highast gra	ucation da com <i>plated)</i>	(Giv.	edent's Usi a kind of w	ork dona	during most o	f working	16b. H	(ind of Businass	/Industry	312
Completed	Elementary/Secondary (0-12) 8th	College (1-4or 5+)		stau					Cook		
Be C	17. Fathar's Nama (First, Middla, Last)					18. Mothar's	Name (First, Mid	dla, Maidei	n Sumama)		
To B	William D. Mor:	ris				Eth	el Gipe	9			
er trauma	19a. Informent's Name/Ralationship (7) Norman Hicks/						or Rural Routa Nu Baltin				
x othe	20a. Mathod of Disposition  1 XBurial 2 Cramation 3		b. Place of Disp camatary, cri	osition (Na amatory or	ma of othar pla	ca)	Data	20c. L	ocation - City o	Town, Sta	ta
, and	4 □ Donation 5 □ Other (Specify		d. Vet	. Ce	mete	ery	9/14	Cro	ownsvi.	lle,	Md.
any in	21. Signature of Funaral Sarvice Licen	Damisou	1 4	001	Rito	chie F	Gonce lawy. Ba	ltimo			
cian	23á. Part1. Entar tha diseasa, or corn shock, or heart feilura. List only	dutions thet caused that cause on each line.	death. Do not er	nter the mo	de of dyir	ng, such es ca	rdiac or raspirator	y arrest.			rimete il Between and Death
dical niner	Immedieta Causa (Final diseesa or condition resulting in death)	· Metast	to (or es a conse	369	2	ZnCe	5			6	Minh
in and ital-transit Examiner	Sequentialty list conditions,	b	to (or as a conse					100			
the bur	if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that Initiated events rasulting in death) Last	c	o (or as a conse							1	
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ed to	Part II. Other significant conditions of	entributing to death but no	rasulting in tha	undarlying	causa gh	van in Part I.	23b. [	old tobacc	o use contribut	e to the ca	use of death?
detached for use							1	□ Yes	2□ No 3□1	Probably	12 Unknow
shoul ete.								vas an auto erformed?	opsy 24b	Were auto aveilable p complation of death?	ppsy findings prior to n of causa
director, page To Be Com							1	□ Yas 2	2 No	1 🗆 Yea	2 No
rector, page 2	25. Was casa rafarred to medical examinar?					26. Pleca o	f Death (Check or	ly one)			
0 0	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatiant	2 ER/Outpatio	ent 3 C	OA Oth	er: 4E Nurs	ing Homa 5□ R	lasidanca	6 □Othar (Sp	ecify)	
Director: After the din by the funeral Certification:	27. Menner of Death  1. Netural 5 Pending 2 Accident Investigation	28a. Date of tnjury (Month, Day Year) 28b. Tima of 28c. tnjury at 28d. Da Work?						oma 5 ☐ Rasidanca 6 ☐ Othar (Specify)  28d. Dascribe how injury occurred			
completely filled in by the funeral Medical Certification:	3 ☐ Sulcida 6 ☐ Could not be 4 ☐ Homicida datermined	28a. Place of Injury - building, atc. (Sp	At homa, farm, s	treet, facto	ry, offica		28f. Location City or	n (Street a Town, Stat	nd Number or F te)	Rural Routa	Number,
pletely fille	29a. Certifier Certifying Phy (Check only one) 2 Medical Exam	relcian: To the best of my iner: On the basis of star	owledge, dea ni ation and/or i	th occurred	d at tha tii n, in my c	ma, data and ppinion, deeth	place, and dua to occurred at tha tir	tha causa(i ne, deta er	a) and mennar and place, end du	as stated.	use(s)
completely filled	29b. Signatura and titla of codifier	// //		2	c-Licans	a number		29d. D	ata signed (Mor	oth, Day, Ye	ear)
,	16/6	. /			1)4	547	5	9	- 12	- 2	000
2	30. Nama and address of person who o	complated causa of daath	(ttem 23a) (Type	, Print)							
	MICHAMMAD	KEZA K	AHNA	MA	m	ANOR	CARE	HE	ALTH SI	ERNIC	ES
State	31. Date filed (Month, Day, Year) SFP 1 4 200	32. Registrar's S	ignatura &	-11	De Ka	1					



			State of N	naryianu		ertificate			IIIU IV		eg. No.	0 29036		
	Physician	1. Decedent's Name (First, Middle, Last)								2. Dete of Deeth Month Day Year  3. Time of Death				
E	/Medical	Connie Lee Ireland								SEPTEMBER 11, 2000 4:00 AM				
A l	Examiner	4b. City. Town, or Lo St. Agnes Hospital  Baltimo												
V. 3		5 Could County Number 6 County 17 Acre (to use test high four) If Under 1 Year   If Under								8 Dete of Birth		9. Birthplace (State or Foreign		
	Enucator and Director	214-64-8306  Usuel Residence of Decedent			Yrs. Months Dey			s Hours Min. DEC			, 1954 Maryland			
yland		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits												
o Ma		Maryland Baltimore					Arbutus					1 Yes 2 No		
th with th		10e. Street and Number 5527 Dolores Avenue				10f. Zlp Code 21227					10g. Citizen of Whet Country? USA			
r dea	iner mat	11. Meritel Stetus	12. Was Decedent Ever in U,S. Armed Forces?			13. Wes Decedent of Hispenic Origin? (Sp If Yes, specify Cuben, Mexican, Puerto			cify Yes or No- Rican, etc.)		e - American Indien, k, White, etc.			
Maryland 21215-0020 32 should be filed within 72 hours after	by by	3 Widowed 4 Divorced	1 Yes 2 XNo If Yes, Give Yeer or Detes:			1 ☐ Yes 2 ☒ No Specify:				Speci		White		
25.0	er then 'nature t, the Medical.	15. Decedent's ( (Specify only highest p	15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)					16b. Kind of Bu	b. Kind of Business/Industry		
121	han han	Elementary/Secondary (0-12)	Elementary/Secondary (0-12) College (1-4or 5+)								Factory			
D D		17. Father's Neme (First, Middle, Last)			Laborer 18. Mother's Ner					FACCOLY  e (First, Middle, Meiden Sumeme)				
lan d by	ked off	William Brooks					Unk.							
any	umati umati	19a. Informent's Neme/Reletionship	19a. Informent's Neme/Reletionship (Type, Print)								orel Route Number, City or Town, State, Zip Code)			
, M	1 27 h	William Irela	nd/husband	d	552	27 Dolo	res	Aven	ue	Arbutus	,			
Pages 1	Department of He Important: If then any Injury or oth ance.				note of Disposition (Name of malery cremetory or other place)				9	/12/00		City or Town, State  ore, MD		
Balt		21. Signeture of Funeral Service Licensee				Cremation Society of				of Mary	of Maryland, Inc.			
		Thomas Gregor  299 Frederick Road Baltimore, MD 21228  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feiture. List only one cause on each line.  Approximate interval Between												
//	ysician Medical kaminer	Immediate Cause (Final disease or condition resulting in death)  a.metastatic ceruical cancer years  Due to (or es a consequence of):												
· Boul	and al-tran	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying												
760	siciar e burta cal E	T Cause (Disease or injury												
Box 68	25.27 100	reculting in death) Leat	Due to (or es e consequence of):											
1000	d for a	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.								23h Did to	shacco usa cor	ntribute to the cause of death?		
P.O.	ed by the attending physician to use as the physician/Med	Lyperter	S 100							1 Yes 2 No 3 Probably 4 Unknown				
Records,	page 2 should be c	31								24e. Wes a	in autopsy med?	24b. Were eutopsy findings available prior to completion of cause of deeth?		
He s	ge 2	Entra State State								101	es 2 No			
E E		25. Wes case referred to medical	I	1 Yes 2 No 1 Yes 2 No										
Palcia S	director director	examiner?	Hospitel:	Other										
on of	Ather this funeral of tion: T	27. Menner of Death  1 Seturel 5 Pending 2 Accident investigati	28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury Work?							28d. Describe how Injury occurred				
Division of or Attending Phy	is after death.  al Director: After led in by the funeral of in by the funeral Certification:	3 Suicide 6 Could not determine	28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, Stete)											
Hospita	Funer feely fill files!													
Tothe	To the comple	29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)												
)	N	1 De Wine (Minor) 10 MO (23305)							September 11, 2000					
(	R.	30. Name and address of person who	completed ceuse of	death (Item 2	23e) (Type	e, Print)	0	14/		250	3017	work		
	State	31. Dete filed (Month, Day, Year)	32. Regis	strer's Signety	1 1 3c	100	10	acc	>C	110	back	214/01/0		
	Registrar	SEP 1 4 2000	Deney	2	1. 1	park	1							

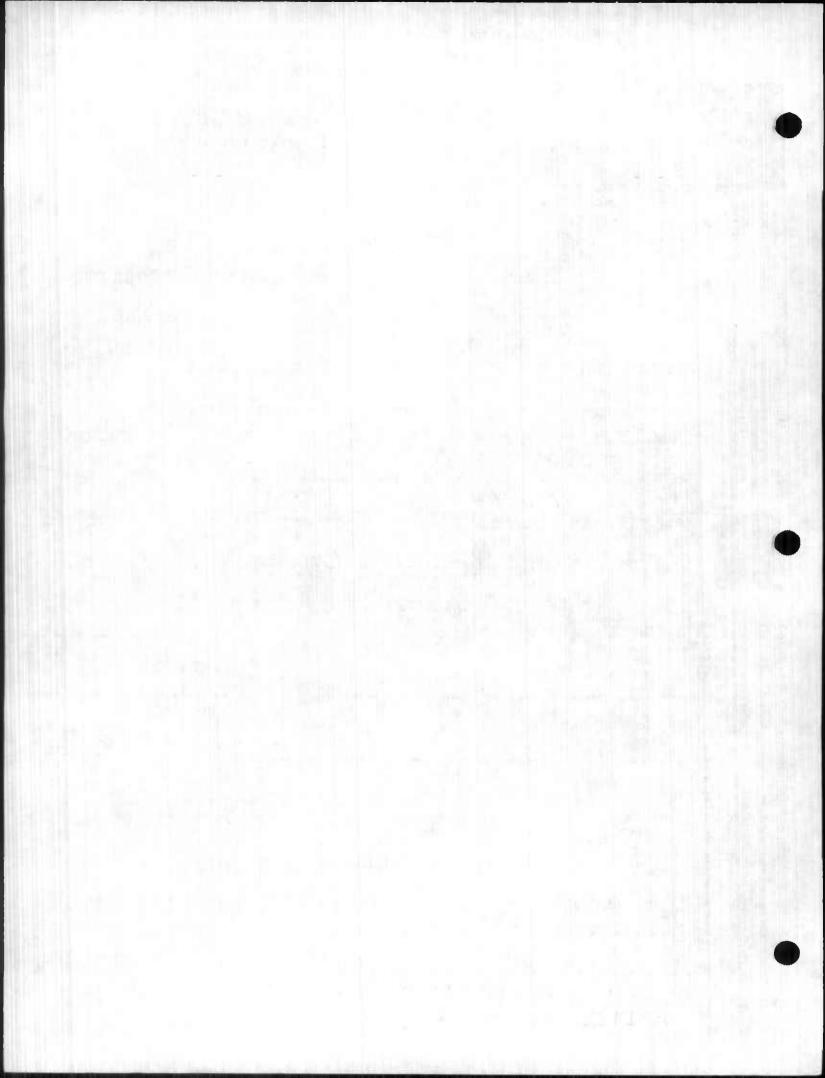
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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Department of Health and Mei	ntal Hygiene	nn	2	0	n	2	7
Certificate of Death	Reg. No.	00	6	)	U	J	-1

			Certificat	e of Death		leg. No.	00 23031		
Dharatalan	1. Decedant's Nama (First, Middle, Last,		ON STATE OF		2. Date of Dea Month	th Day	3. Tima of Death Year		
Physician /Medical	hosetta	Jones				ber 11, Z			
Examiner	4a Facility Nama (If not institution, give			4b. City, Town, or l	ocation of Death	4c. County	of Death		
	1603 North Long	wood Street	2+	Baltim					
Funeral	5. Social Security Number 6. Sec	1	Months	1 Yaar If Undar 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day 8-28	, Year)	Birthplace (State or Foreign Country)		
Director	212-44-3340	<sup>1</sup> M <sup>2</sup> √ F 59	Yrs.		8-28	3-1941	Md		
P .	Usual Residence of Decedent  10a, State 10b, County	100 City	Town or Location				10d. Inside City Limits		
style style data							1√2Yes 2□ No		
ne diffe	Md N/A	Bait	imore				7		
a with the Ma Sa or 28s-f a at be notified if Directo	10e. Street and Number 1603 N. Longwood	Street		10f. Zip Code 10g. Citizen of What Country?					
ner death v r here 23 siner.mat	11. Marital Status	12. Was Decedent Ever in U,S	13. Was Dece	dent of Hispanic Origin? (S cify Cuban, Maxican, Puert	pecify Yas or No-	14. Raca	- American Indian,		
020 020 Exam	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		cify Cuban, Maxican, Puert	o Rican, etc.)		Black		
5-0 72 h	15. Decedent's Edu (Specify only highast grad	cation	16a. Decedent's Usu	el Occupation	kina	16b. Kind of Bu	siness/Industry		
1 21215-0 led within 72 ho typiens. We then 'nature It, the Medical. Completed	Elementary/Secondery (0-12)	College (1-4or 5+)		Sive kind of work done during most of working le. DO NOT use retired)					
Co wash	6th grade	N/A	Houseke				son Hotel		
Be done	17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle,	Maiden Sumami	e)		
Via Manual Misses To	James Sparrow			Mary Sp	arrow				
S sho	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Melling Address	s (Street and Number or Ru	ral Route Numbe	r, City or Town,	State, Zip Coda)		
- 65% 5	James E. Jones			ongwood Stre	et Balt	imore, M	d 21216		
Baltimore, ormit. Pages 1 a supartment of Ha mportant; if law my injury or other side.	20a. Method of Disposition	20b. Pla	aca of Disposition (National Control of Cont	me of other place)	Data	20c. Location -	City or Town, State		
Pag Pag	1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	VOS	hell Cemet	ery	9-16-00	Baltimo	re, Md		
alt municipality of the party o	21. Signature of Funeral Service, License	00/		nd Address of Facility			1 -1251 - 5		
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THE RESERVE OF THE PERSON NAMED IN	23a. Parf1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death.	Do not enter the mod	Wabash Aven de of dying, such as cardiac	or raspiretory er	rest.	Md 21215 Approximate		
Physician	shock, or heart failure. List only or	ne cause on each line.					Interval Between Onset and Death		
/Medical	Immediate Cause (Final	Pana	oran La	00000					
Examiner	disease or condition resulting in death)	<u>ranc</u>	reanc	Cance					
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The law requir atte has been a page 2 should Completed					perfo	med?	available prior to completion of cause		
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Of Vital   Physician: The this certificate ral director, page 1: To Be Co	25. Was case referred to medical examiner?				th (Check only o	ne)			
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Division or Attending after death. Director: After I in by the fune ertification	2 ☐ Accident investigation		М	1 ☐ Yas 2 ☐ No					
Visit Am	3 Suicide 6 Could not be determined	28e. Placa of Injury - At hor building, etc. (Specify)	me, farm, street, factor	y, office	28f. Location (5 City or Tox		er or Rural Route Number,		
Division of that or Attanding P its after death.  al Director: After to led in by the funers Certification:									
Ne Hospit n 24 hours se Funer pletely fill edical	29a. Certifier 12 Certifying Phys	sician: To the best of my knowner: On the basis of examinetic	riedge, death occurred	et the time, date and place	, end due to the	cause(s) and ma	nner as stated.		
	one)	and manner stated.			TO BE UIE UITIO,	auto ano piace, i	due to the cause(s)		
To the com	29b. Signature and title of certifier	MARKET FL	29	c. Licansa number		29d. Data signed	(Month, Day, Year)		
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X	30. Nema and address of person who co	empleted cause of death (Item	23e) (Type, Print)	1/		1			
	16 South &	utaw Sti	reet .	Baltimore	2. Ma	rulano	21201		
State	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ure /		)	J			
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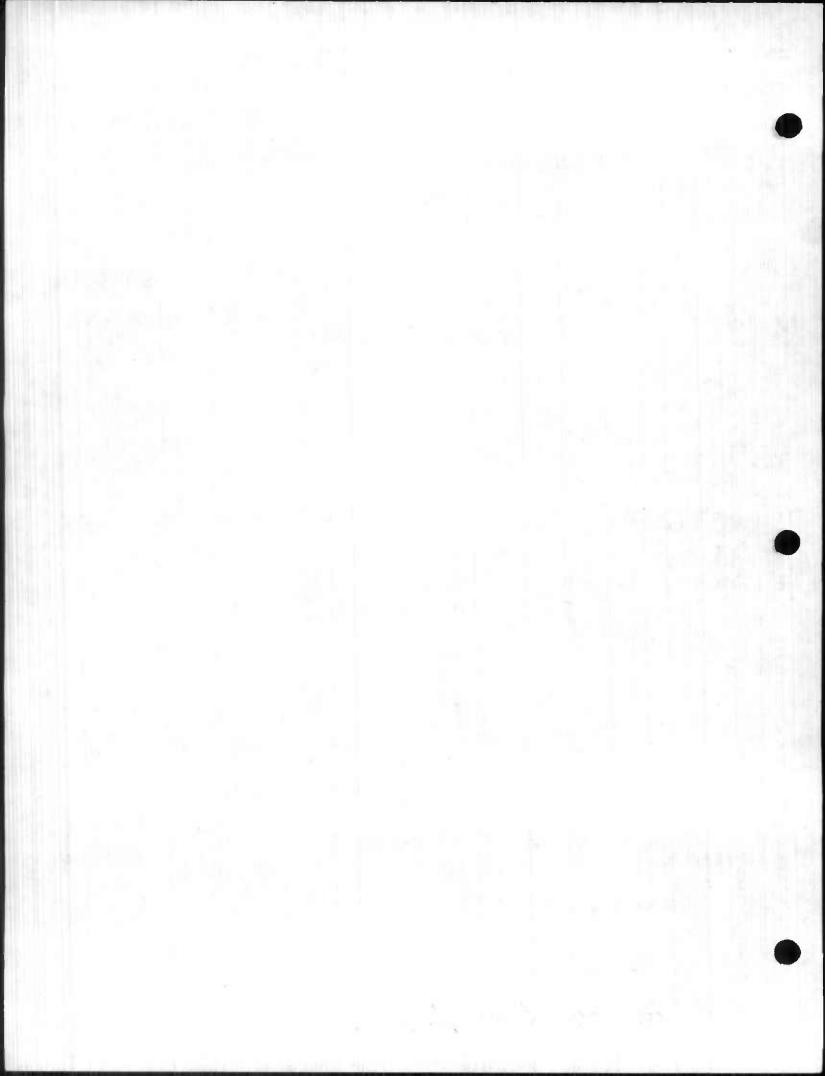


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Social Security Number  18  UNKNOWN  Sual Residence of Decedent  Se. State  10b. County  IARYLAND  ANNE ARUL  Street and Number  308 ELIZABETH AVE  Merital Status  1 Never Merried  1 Married	NDEL CO.	41 10c. City, Tow	Yrs. Months		If Under:	24 Hrs.			0 Birtholas		
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		ever in U,S.	13. Was Dec	edent of	Hispanic Orl	gin? (Spe	ecity Yes or No-		e - American		
3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 N If Yes, Give Year or Dates:	lo	1□ Yes					Specify: BLACK			
15. Decedent's Edu	ucetion	16a	. Decedent's Us	ual Occu	ccupation 1			16b. Kind of Br	usinass/Indu	stry	
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	Removel from State				ace)		Date	20c. Location -	City or Town	n, State	
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1. Signature of Fitheral Advisor Dicord	he		22. Name	nd Addr	ess of Facilit	y					
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Manner of Death	28a. Data of Injur	y Year) 28b.		28c. Inj	ury at		28d. Describe h	ow Injury occur	rred		
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3 ☐ Suicide 6 ☐ Could not be	28a. Place of Inju			ory, office					ber or Rural I	Route Nu	nber,
4 Homicide	building, ato	UND I	N DWEL	LINC	3		BALTIN	n, State) 82	MARER	NBBI	1 CJ
(Check only 2 Medical Exam	eiclan: To the best of Iner: On the basis of	of my knowledge examination ar	e, death occurre	d at the	ime, data an	d place,	and due to tha c	ausa(s) and m	annar as stat	ed.	
9b. Signature end title of certifier	and menner sta	.tea.	2	9c. Licer	ise number			29d. Dete signe	ed (Month, Di	ay, Year)	
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Elemis!	Crutta no			0.	C.M.E.	•		SEPTEM	BER 7,	200	)
	Specify only highest grace   Specify only highest grace   State   St	Father's Name (First, Middle, Last)  UNKNOWN  Pa. Informant's Name/Ralationship (Type, Print)  DORETHA STEWART/MOTHER  Pa. Method of Disposition  XXBuriel 2 Cremetion 3 Removel from State  4 Donation 5 Other (Specify)  I. Signature of Disposition  ACUT  Sa. Part I. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line  Immediate Cause (Final sease or conditions, entry, leading to immediate ause. Enter Underlying ause (Disease or injury at initiated events sulking in death) Last  I. Other significant conditions contributing to death but also introduced examiner?  I. Name of Death  I. Natural investigation of Could not be datarmined  Pa. Cartifier (Check only one)  Pa. Cartifier (Check only one)  D. Name end address of person in completed cause of death of the could be death one)  D. Name end address of person in completed cause of death of the could be death one)  D. Name end address of person in completed cause of death one)  D. Name end address of person in completed cause of death one)  D. Name end address of person in completed cause of death one)  D. Name end address of person in completed cause of death one)	Collega (1-4or 5+)   Selemantary/Secondary (0-12)   Selemantary/Secondary (0-12)   Selemantary/Secondary (1-4or 5+)   Selem	College (1-4or 5+)   College	College (1-4or 5+)   ONOT use relifie. DO NOT use relifie.	College (1-4or 5+)   College (1-4or 5+)   (Giree kind of work done during mos life. DO NOT use retired)   (Giree kind of work done during mos life. DO NOT use retired)   (Giree kind of work done during mos life. DO NOT use retired)   (Giree kind of work done during mos life. DO NOT use retired)   (Giree kind of work done during mos life. DO NOT use retired)   (Giree kind of work done during mos life. DO NOT use retired)   (Giree kind of work done during mos life. DO NOT use retired)   (Giree kind of work done during mos life. DO NOT use retired)   (Giree kind of work done during mos life. DO NOT use retired)   (Giree kind of work done during mos life. DO NOT use retired)   (Giree kind of work done during mos life. DO NOT use retired)   (Giree kind of work done during mos life. DO NOT use retired)   (Giree kind of work done during mos life. DO NOT use retired)   (Giree kind of work done during mos life. DO NOT use retired)   (Giree kind of work done during mos life. DO NOT use retired)   (Giree kind of work done during mos life. DO NOT use retired)   (Giree kind of work done during mos life. DO NOT use retired)   (Giree kind of work done during mos life. DO NOT use retired)   (Giree kind of work done during mos life. DO NOT use retired)   (Giree kind of work done)   (G	College (1-4or 5+)   College	Capecity only highest grade completed	Capeting only injected prace completed:   College (1-for 5+)   College	Genetic only inches grade completed   Genetic only inches   Gene	Continue of the property of the property grade completed   Color (14-of-5+)   Color (14

Registrar

SEP 1 4 2000



#### Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** JOHANNS 11 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hospital Glen Burrie orth trundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 100 M 2□ F Months Days Hours Yrs. 218-42-2660 Usual Residence of Decedent Director July 10, 1943 Maryland the Maryland 10e. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits r 28a-f ehow 1 Yes 2 No Directo Md. Anne Arundel Millersville 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ient of Health and Mental hygiene. This if fem 27 is marked other than naturely, or items 23s or iny or other traumatic event, the Medical Exertise manifer U.S.A. 14. Race - American Indian, 8351 Jumpers Hole Road 21108 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Merital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: by 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 12th 0 NSA Foreman US Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Be Robert Carl Michael Johanns, Sr. Frances Ethel Meseke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Shock ( Daughter ) 54 Benson Avenue Millersville, Maryland 21108 20b. Placa of Disposition (Name of cametery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department of Important: If any Injury or Glen Haven Memorial Park 9/15/00 Glen Burnie, Maryland 21. Signature of Juneral Service Licensee Kevin E. Ecker McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Avenue Baltimore, Maryland 21225 shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner eriosclerotic Examir Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequença of) physician the buria Box 68760 edical Due to (or es e consequenca of) Physician/M 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Onknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was en eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after dead Director: 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 8 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) and manner as steted. Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and placa, and due to the ceuse(s) end manner stated. 29e. Certifier edical To the within 2 To the Deputy 29b. Signeture end title of cartifier 29d. Date algned (Month, Day, Year) 29c. License number pt 00

State Registrar

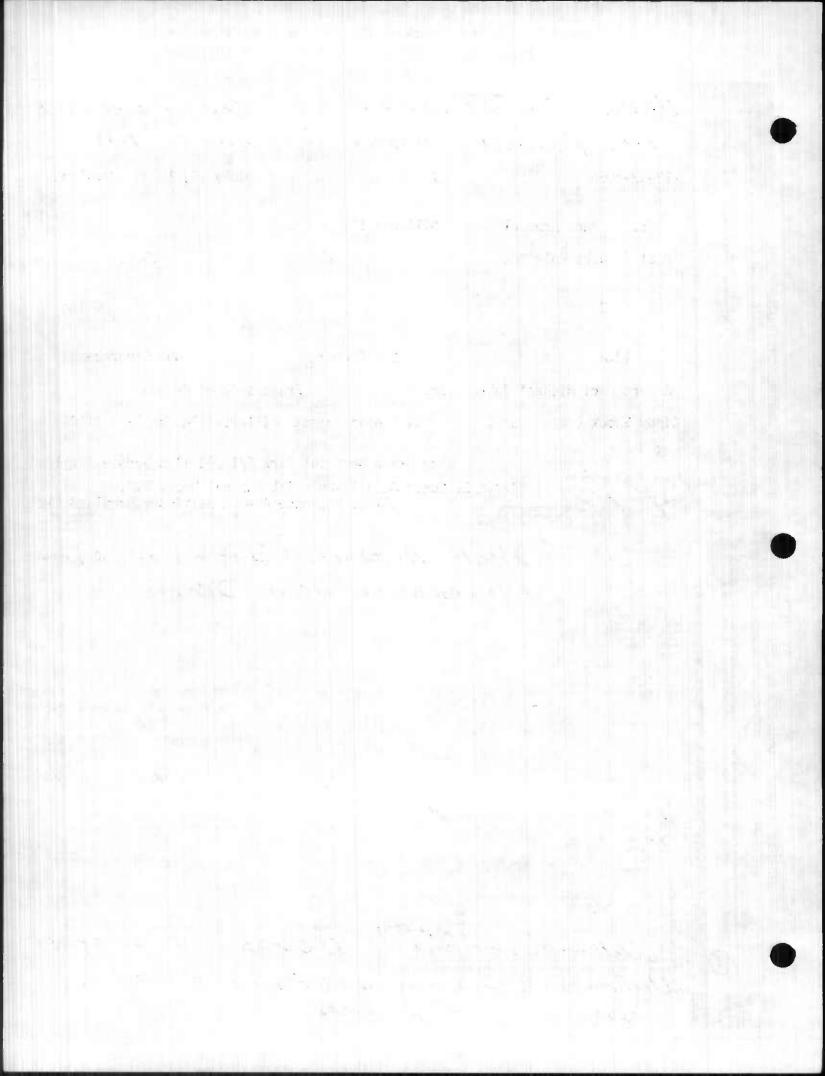
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31. Date filed (Month, Day, Year)

32. Registrer's Signature

ne end address of person who combleted cause of death (Item 23e) (Type, Print)

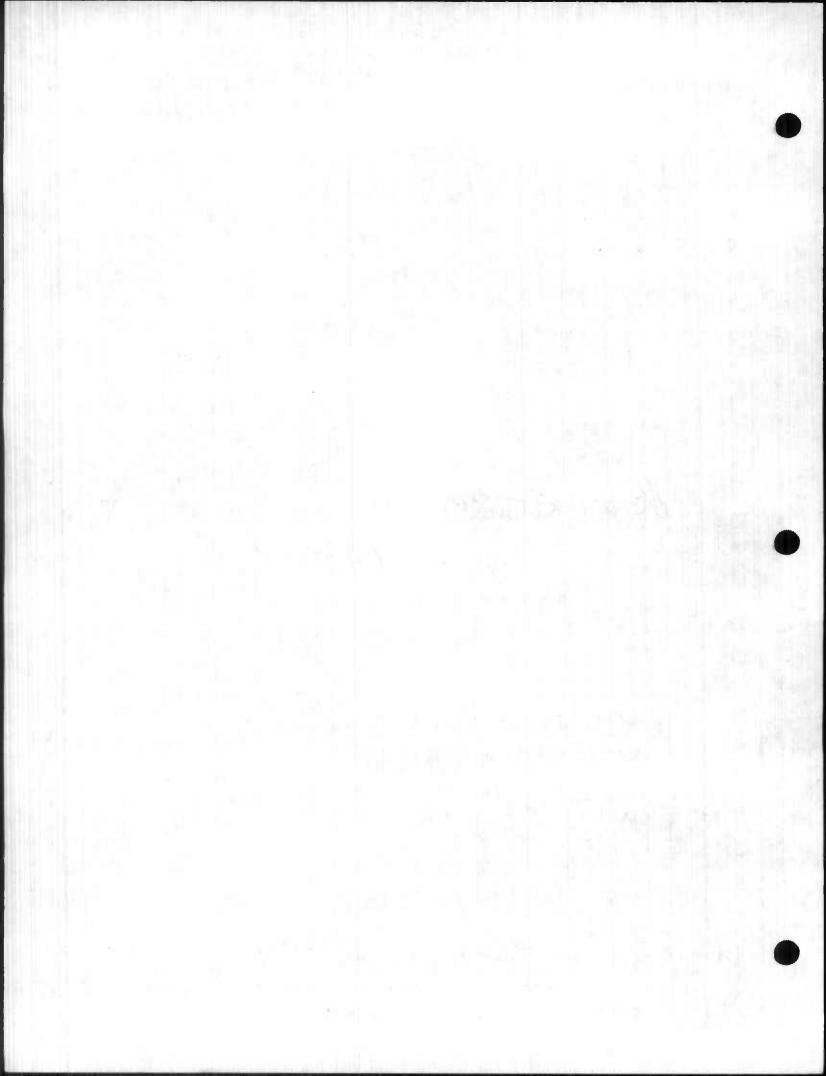
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State of Maryland / Department of Health and Mental Hygiene

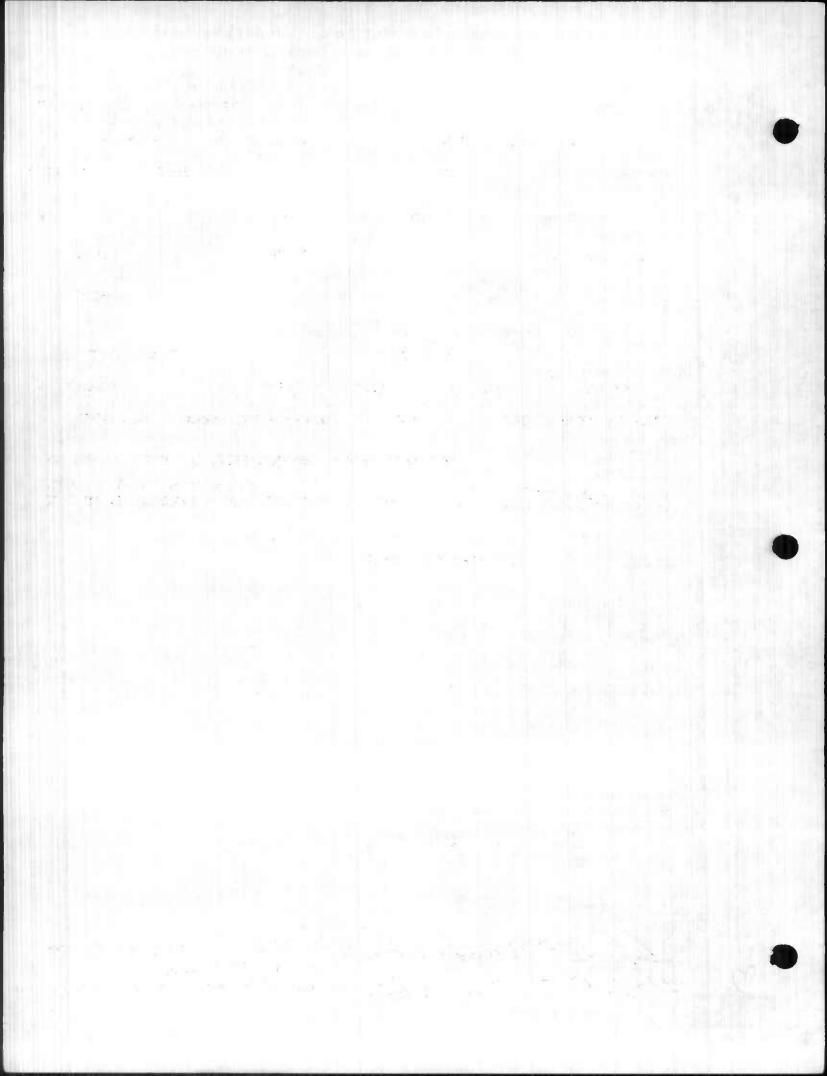
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	Certificate of Death		Reg. No.		
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hysician /Medical	Kuth Kenpr	Sept		00 8:237	
xaminer	4a Facility Name (If not institution, give street and number) 4b. City, Town	n, or Location of Death	4c. County of	f Deeth	
	Good Samaritan Hospital Bay	1 timor	TMOVE NA		
neral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Undar 24	Hrs. 8. Date of Bir	th	9. Birthplaca (Stete or Foreign	
ector	219-20-7627 1 M XX 88 Yrs. Months Days Hours	Min. (Month, Da 09-0	1-12	Country) SC	
	Usuel Residence of Decedent				
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Director	10e. Street and Number 10f. Zip Coda		10g. Citizen of Wh	nat Country?	
al Die	533 E. 20th Street 21218		USA		
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Funer	Armed Forces? If Yas, specify Cuben, Mexican, I	Puarto Rican, etc.)	Bleck,	Whita, etc.	
by F	1 Nevar Merried 2 Merried 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify:		Specify:	D11-	
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Completed	15. Decedent's Education (Specify only highest grade completed)  18e. Decedent's Usuel Occupation (Give kind of work done duning most of life. DO NOT use retired)	of working	16b. Kind of Busi	iness/Industry	
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jury or other	20a. Method of Disposition 20b. Place of Disposition (Neme of	Dete		City or Town, Stata	
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	21. Signature of Funeral Service Libenses 22. Name and Address of Facility				
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	WM.C. March FI	H 1101 E	. North	Avenue	
	23a I will. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cannot, or heart tailure. List only one cause on each line.	ardiec or respiretory e	rrest,	Approximete Interval Between	
an				Onset end Deeth	
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d by	Diabetes Mellitus. Dementia	24a Was	an autopsy	24b. Were autopsy findings	
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Cat	2 Accident			0 (0	
tiff	3 ☐ Suicide 4 ☐ Homicide  Could not be determined  28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	28f. Location ( City or To		r or Rurel Route Number,	
Certification:	• • • • • • • • • • • • • • • • • • • •				
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edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth and menner steted.	occurred at the time,	dete and placa, ar	nd due to the ceuse(s)	
Me	29b. Signature end tilla of certifier 29c. Licansa number		29d. Data signed	(Month, Day, Year)	
1	151 0 AC 1 D2000	7-	Cosp. 1	e. 9 2000	
1	Jan (350m) 13893		Sykno	a 1, xvu	
	30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)  Edward A. Seidel MI), 5601 Loch Raven Blad	1011	/	11	
1	Edward A. Seidel MD. 5601 Loch Kaven Blief	, Baltin	nore, MR	4. 21239-29	
State	31. Date filed (Month, Day, Year) 32. Registrar's Signeture				
State	SEP 1 1 2000 Server 19 April				



State of Maryland / D	epartment of Health	and Mental	Hygiene
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Director	10e. S	treet and Nu						10f. Zip					10g. C	itizen of \	What Count	ry?	
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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#10f,12 perFHG787 9/14/2000 EW 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** Norville 2000 6:20 AM 11 JULIV /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examine Takomafark Montgomery Hospital Adventist Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Months 52 Yrs. 578-56-1203 August 22, 1947 Washington, DC **Director** Usual Residence of Decedent the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 N Yes 2 No Director Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1229 G Street S.E. permit. Peges 1 end 2 should be filed within 72 hours after death 1. Department of Heelth end Mental Hygiene. In proclam: If Item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examples 2008. 20003 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritel Status Black, White, etc. 1 Never Merried 2 Merried **Black** 1 Yes 2 No Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 9th College (1-4or 5+) Custodian D.C. Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Eatie Mae Lott Claude Jones 0 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2119 Scott Key Drive, Forestville, M.D. 20747 19a. Informant's Neme/Relationship (Type, Print) Phyllis L. Lott 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 X Buriat 2 ☐ Cremation 3 ☐ Removal from State 7/15/2000 Forest Hills Cemetery Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert G. Mason Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximate Intervai Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner deficiency Syndrone Examiner certificate be executed ettending physician end for use as the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Shock Physician/Medical Due to (or as a consequence of): 88 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 鲁 detached signed by t 3 Probably 4 Lunknown 1 ☐ Yee 2 ☐ No ρ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? has 1 Yes 2 No 1 ☐ Yes 2 ☐ No director. 25. Wes cese referred to medicei examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funerai 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? After Certification: or Attending F efter deeth. 1 Natural 5 Pending Investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours

State Registrar

within 2 the

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altimore, Maryland 21215-0020

Division of Vital Records. P.O. Box 68760.

31. Date filed (Month, Dey, Year)

29a. Certifier

(Check only one)

29b. Signeture and title of certifier

DusenRo

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Van

32. Registrar's Signeture repers

aurel MD 220 ones

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner stated.

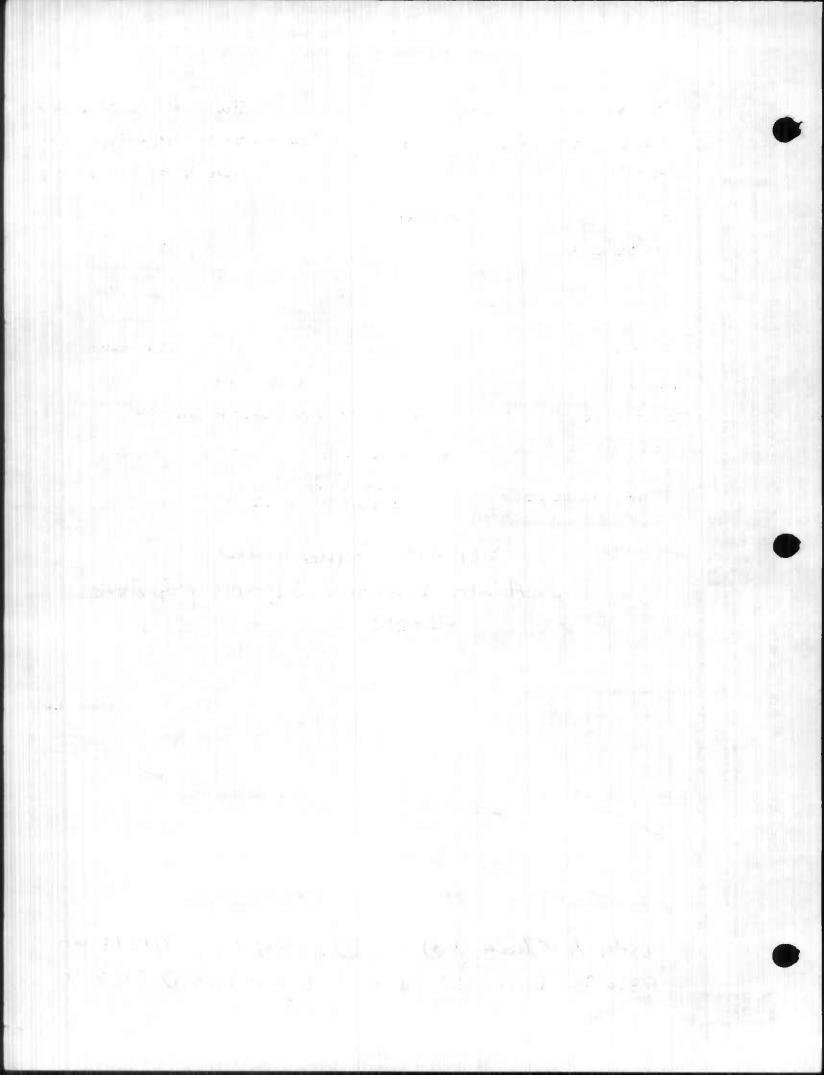
29c. License number

29d. Date signed (Month, Day, Year)

SEP 1 4 2000 >

**DHMH 16 Rev 6/95** 

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#23a perPHYG787 9/14/2000 EW Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** .00pm 7,2600 EPTEMBER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) **Examiner** ltimore If Under 24 Hrs. using If Under 1 Year Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In y/s. last birthday) **Funeral** Days 1 M 2 F anuary 11,194 Director Usual Residence of Decedent filed within 72 hours efter death with the Maryland 10a. Stete 10d. Inside City Limits 10b. County or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21229 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2 No Be Completed by 3 NWidowed 4 □ Divorced Yeer or Dates: "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO,NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. dary (0-12) College (1-4or 5+) 10, Department of Health end Should be file Department of Health end Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic event, DOCS. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 19a. Informant's Name/Relationship (Type, Print) aaugtta 19b. Malling Address (Street and Number or Rural Route Number, City of Town, Stete, Zip Code) 21220 temere, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Ø Burial 2 ☐ Cremetion Dete 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Lin 22. Name and Address of Fecility Talper Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest about, or heart failure. Use unity one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examinine Due to (or as a consequenca of) Be Completed by Physician/Medical Examiner ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I 23b. Dtd tobacco use contribute to the cause of death? 4 Unknown been signed by should be detact 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 1 Yes 1 Yes papital or Attending Physician: The hours after death. Ineral Director: After this certificate by filled in by the funeral director, pa 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 208 No Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA 48 Nursing Home 5 Residence 6 ☐Other (Specify) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred tnjury at Work? Netural 2D Accident 5 Pending 1 Yes 2 No investigation 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

To the Hospital of within 24 hours at To the Funeral D completaly filled is

29a. Certifier (Check only one) 29b. Signature and title of certifie

1 Sectifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and menner as stated
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

2000

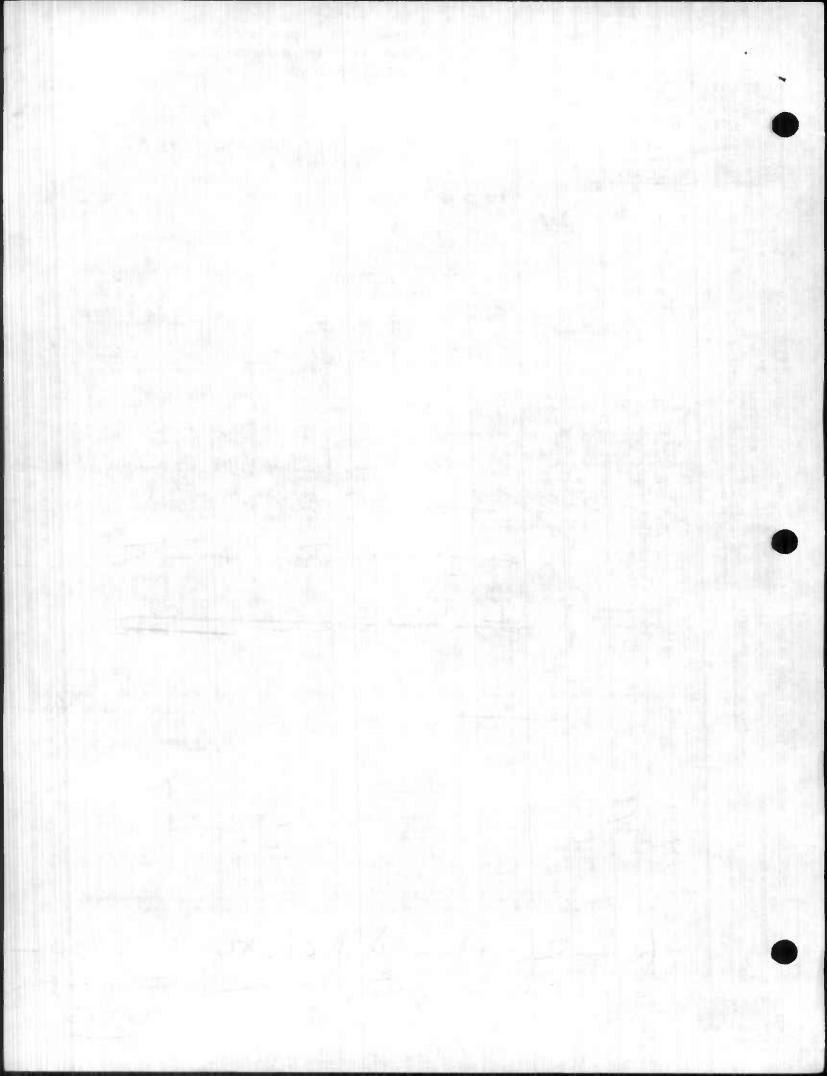
Year) 14 32. Registrar's Signature

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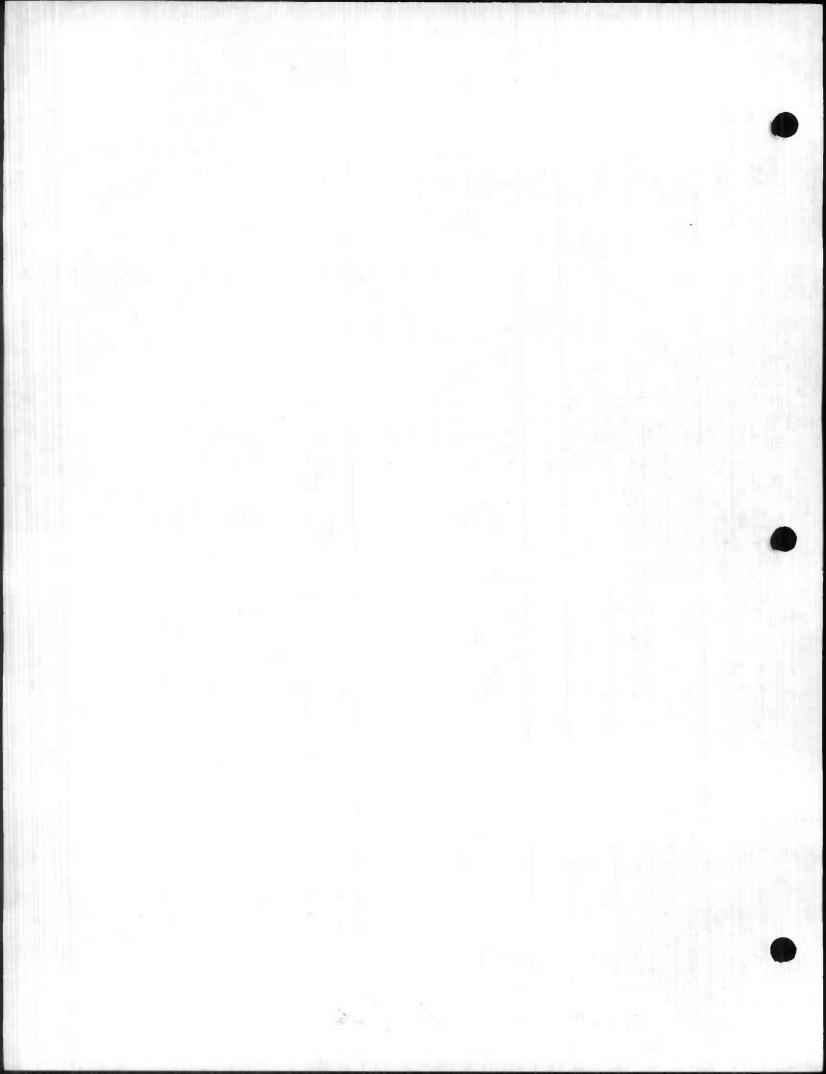
B.K.S

State of Maryland / Department of Health and Mental Hygiene

PETER LAPAGLIA AMEND ITEMS: #23 PART I, 27 Centrate of Death G787 9-20-0 0

Reg. No. WR.

	Decedent's Nama (First, Middle, Last)	2. Dete of De		3. Tima of Death				
Physician /Medical	Peter Louis Lapaglia	SEPT.	11, 2000	0927 AM				
Examiner		ity, Town, or Location of Death	4c. County of Death	And the latest terminal				
Funeral Director		Juder 24 Hrs. 8. Deta of Bir Ours Min. (Month, De MALCh	th (9. Birth 6, 1961 Ma	placa (State or Foreign intry) LYLand				
Du B	Usual Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits				
death with the Maryland ms 23s or 28s-f show Invest be notified at	Maryland N/A Baltimore			1 □XYas 2 □ No				
23a or 2 uat be n	10a. Street and Number 10f. Zip Code 212	234	10g. Citizen of What Co. U.S	U.S.A.				
or he	Armed Forcas? If Yas, specify Cuben, Me	nic Origin? (Specify Yas or No axlcen, Puarto Rican, etc.) pecify:	pecify Yas or No- o Rican, etc.)  14. Race - American India Black, Whita, atc.  Specify: White					
natural	15. Decedant's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during	most of working						
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tai Hy d othe event,			ame (First, Middle, Maidan Sumama)					
Ments	Zaragie Zapagiesa	Rose Puzzo						
2 8 8 8	19a. Informant's Name/Ralationship (Type, Print)  19b. Mailing Addrass (Street and N							
1 and Health om 27 ther t	Mr. Luigi Lapaglia (father) 9201 Ramblebrook  20e. Mathod of Disposition (Nama of	or Koaa, Ball	20c. Location - City or 1	1236				
permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other to ance.	1 Burial 2 Cremetion 3 Ramovel from Stata 4 Donation 5 Cothar (Specify) Entombment Dulancy Valley Maus							
permit. Page Department of Important: If any Injury or once.	21. Signature of Funaral Service Licensee 22. Nama and Addrass of Schimunek Ft 9705 Belair	uneral Home, Rd. Baltimo	Inc. re, MD 2123	6				
	23a. Part T. Entar tha disaase, or complications that caused the daeth. Do not antar tha moda of dying, su shock, or heart failure. List only one cause on aach line.	ich as cardiac or respiratory a	mast,	Approximete Intarval Between				
Physician /Medical Examiner	Immediate Causa (Finat ACUTE NARCOTIC disaasa or condition rasulting in death)	INTOXICATIO	N	Onsat and Death				
è	Due to (or as a consequence of):							
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ne death certificate be executed the attending physician and ched for use as the burial-transit ysician/Medical Examiner	that initiated events resulting in death) Last  Due to (or es a consequence of):  d.							
death of for a	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in	Part I 23h Did	tobacco use contribute	to the cause of deat				
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The law ate has page 2		180	Yes 2□No	Das 2□ No				
certific inector	axaminar? Hospital: Other	Placa of Death (Check only		MAINT SCENE				
	27. Manner of Death 28a. Data of Injury 28b. Tima of 7 28c. Injury at		how injury occurred	WAT SCENE				
Attending in death.  actor: After by the fune liftcation	2 Accidant Investigation 9-11-00 A 0-00 M 1 Yes	2XINo UNKN	OWN					
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Hospi 24 hou Funer tely fil	29a. Cartifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, do 2 Medical Examiner: On the basis of axamination end/or invastigation, in my opinion and mannar stated.	ata and place, and due to the	cause(s) and mannar as	stated.				
To the comple	29b. Signatura end titla of certifier  29c. Licansa nun  O.C.M.		29d. Deta signed (Month SEPT. 12,					
	30. Nama and address of person who complated ceusa of daath (ttam 23a) (Type, Print)							
	Dennis Chute mo 111 Penn Street,	Baltimore, M	aryland 212	01				
State	31. Dete filed (Month, Day, Year)  32. Registrar's Signature							
Registrar	SEP 1 4 2000 Serve B. Sparks							

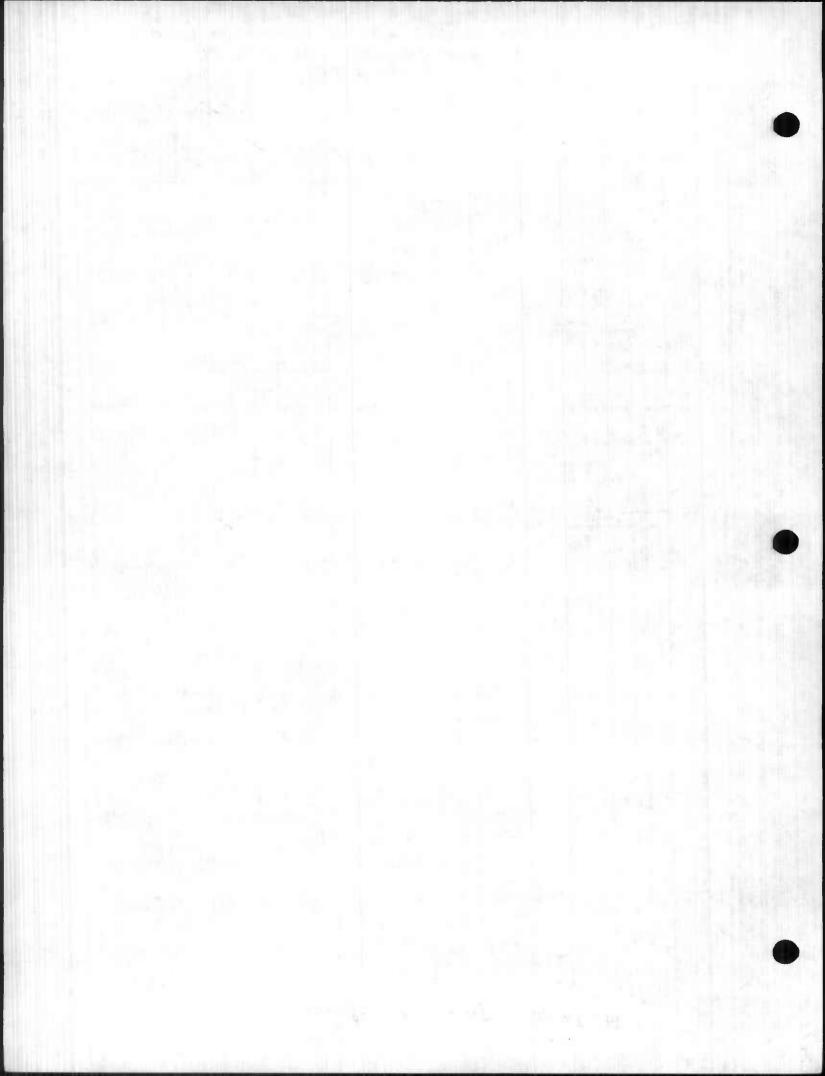


State of Maryland / Department of Health and Mental Hygiene

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	/Medical Examiner	4a Facility Name	(If not institution, gi	ve street end nur	mber)			4	b. City, To		cation of Deat				
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E.	ineral	5. Social Security			7. Age (In yrs. las	t birthday)	If Under	1 Yeer	If Under	24 Hrs.	8 Date of Bi	th	9. Birthr	place (State or Foreign	n
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ytan	show dat	10a. Stete	10b. County		10c. City,	Town or Lo	cation						1	Od. Inside City Limits	
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6	or 28s-1s be notified Director	10e. Street and Nu	umber				10f. Zip	Code	5.1	113	4.	10g. Citizen of	What Cour	ntry?	
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deat	iner must iner must Funeral	11. Marital Status	TWILL TO	12. Was Dece	edent Ever in U,S.	13.	Was Deced	ent of Hi	ispanic Or	igin? (Spe	city Yes or No	- 14. Red	e - Americ		
21215-0020 d within 72 hours after pene.	Examine Examine by Fur	1 Never Men	ried Merried 4 Divorced	Armed Fo	27 No		If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2√ No Specify:			o Hicen, etc.) Ble		ck, White, etc. White			
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S. Share	1-1	shock, or her	the disease, or con art failure. List only	one cause on e	ach line.			,					1	Interval Between Onset and Death	
	sician edical	Immediete Cause	(Final	0.1				1			-b -l-	٠,		, n	
	miner	disease or condition resulting in deeth)	on	a. Mde	nocaro	Inon	na o	T /4	ing	me	etasto	TIC	- 1	11 months	
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	ician and burial-transit al Examir	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury c.													
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0 4		27. Manner of Dea	ath 5 Pending	28a. Date (Mon	of Injury 2 th, Day Year)	8b. Time of	1 2	Bc. Injur Wor	y et k?		28d. Describe	how injury occu	rred		
	ne fu	2 Accident	investigation				M		Yes 2	No					
Division or Attending	tific by the	3 ☐ Sulcide 4 ☐ Homicide	6 Could not 1 determined	288. Place	of Injury - At hom	e, farm, str	reet, fectory	, office		- :	28f. Location	(Street end Num	ber or Run	al Route Number,	
Safe O	al Director: After to do in by the funeral Certification:			02110	ng, old. (opcolly)										
Divisi To the Hospital or Atter within 24 hours after dea	To the Funeral Director: completely filled in by the Medical Certifical	29a. Cartifier (Check only one)	1⊠ Certifying P 2 Medicai Exa	miner: On the ba	best of my knowle asis of examinetion ner steted.	edge, deeth n and/or in	n occurred vestigation	at the tin , in my o	ne, date a pinlon, de	nd place, e ath occurre	end due to the ed at the time	cause(s) end m date and place,	anner as s and due t	othe cause(s)	
To the within 2	To the	29b. Signature and	d title of certifier		^				e number			29d. Date signe			
		D	Coggen	- MI			D	35	584	14	1	Septen	~ ber	13 2000	)
		30. Name and add	iress of person who	completed caus	e of death (Item 2	3a) (Type	Print)					-			-
0		DRogg	en 54	100 010	1 court	Rea	d 1	Cana	dells	town	mo	21136			
	State	31. Date filed (Moi	nth, Dey, Year)	32. R	egls#er's Signatur		4	100	11			Septen 21136			
F	Registrar		SEP 14	2000	Beneva	P	P	you	KS						

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DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** 1:09 AM ewis leveland September 04 2000 /Medical 4a. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Cay Sinai Battimore If Under 24 Hrs. HOSPITAL If Under 1 Yaar 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthpiace (State or Foreign **Funerai** Months Days Hours 10 M 2□ F 2/2-22-/75
Usual Residence of Decedent Yrs. Larolina Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and the first 23a or 28a-f show ant: If them 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Exampler must be notified at ? levelAND, Lewis 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director mor 10e. Street and Number 10g. Citizan of What Country? Heights Funeral 12. Was Decedant Evar in U,S.
Armed Forces?
1 D Yes 2 No
if Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Black Baltimore, Maryland 21215-0020 þ 3 Widowad 4 ☐ Divorced Completed 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working iffe. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) e1 WOS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Lewis Bobert 19a. informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) Ashland Av. granodaughter 25/ Sample Lewis
20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date permit. Pages Depentment of Important: If it any injury or o 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 100 rownsville 4 Donation 5 ☐ Other (Specify) rownsville 21. Signature of Fungral Servica Licansee 22. Name and Address of Facility rvin ( uneral arroll 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line. Balta MD 21211 **Physician** Immadiata Causa (Final disease or condition resulting in deeth) /Medical **Examiner** Examiner ician and burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in daath) Last Due to (or as e consequence of) Box 68760. Physician/Medicai Due to (or as a consequence of): for use signed by the e Part ii. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2000 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 00 No 1□Yas 2□No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No 1 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manper of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Affar 5 Pending investigation 1 Neturai aftar death. 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide within 24 hours a To the Funeral D Hospital . 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Yaer) 0 Septemer 30. Name and address of person who completed cause of death (item 23a) (Type, Print) DENNETT SINAI HOSPITAL

#6

DHMH 16 Rev 6/95

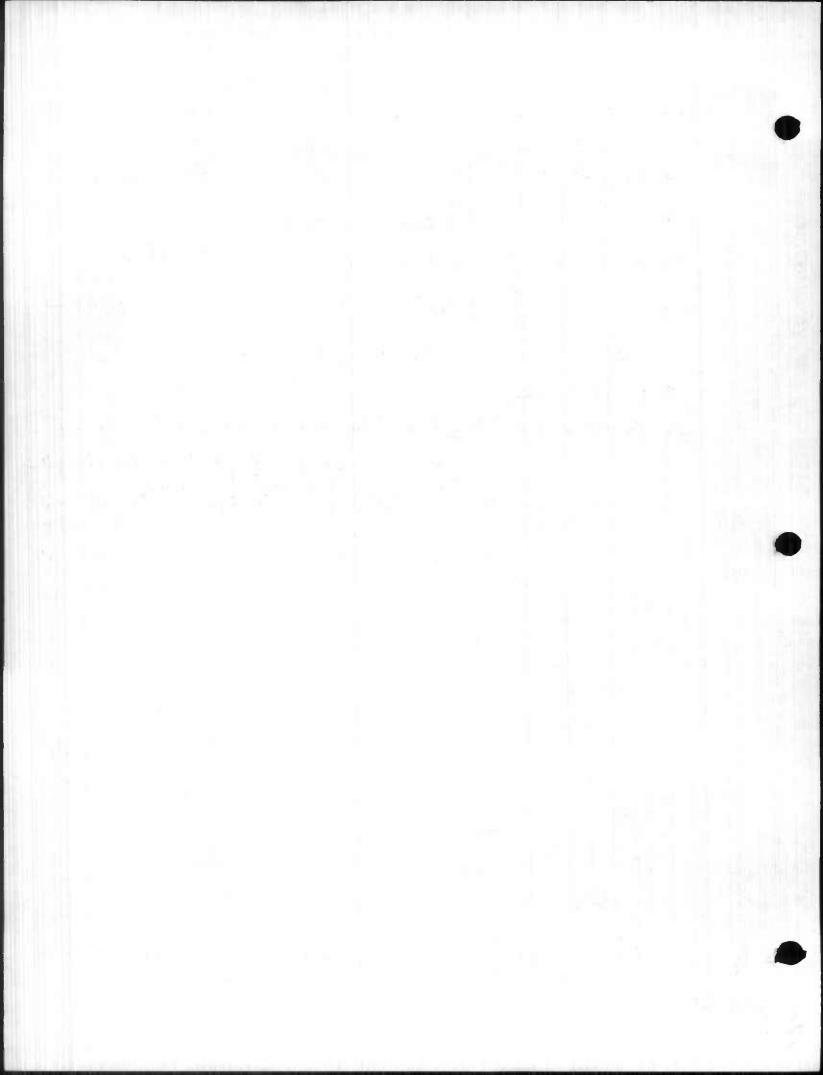
State

Registrar

31. Data filed (Month, Dey, Year)

SEP 1 4 2000

32. Registrar's Signature



**DHMH 16 Rev 6/95** 

Registra

LALVAN

11/03/2000 - Certificate lost - Division of Vital Records - certificate replaced, copies are placed in the VOID folder/dhb approval G. Price original and replacement

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#17 PER F.H. G787 9-14-2000 JAB 2. Date of Death 1. Decedent'a Name (First, Middle, Last) 3. Time of Death September 11 1:52pm 2000 Mumond 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death BA (Timore (it SINAI DSpilAl Timore Timore BA 0 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Se 7. Age (In yrs. iast birthday) Months Days Min 1€M 2□ F 218-12-2866 Meryland Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 12 Yes 2 No Md Saltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Kood en 12. Was Decedent Ever in U.S. Armed Forces? Race - Amarican Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 11. Marital Status 1 → S 2 No If Yas, Give Year or Dates: 1 Nevar Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 2100K 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) lerk 18. Mother's Name (First, Middle, Maidan Sumama) 17. Father's Name (First, Middle, Last) JOHN HENRY MATTHEWS dwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 70 eci 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 Removal from Stata 9-15-200 Maryland Cemetery 4 Donation & Other (Spedity) 22. Name and Address of Facility 21. Signature of Funeral Sarvice Licenses Milker's 1639 N. Broadway Approximata Intarval Between Onset and Death 23a. Part. Enter the disease, or complications that ceusad the death. Do not enter the mode of dying, such as cerdiac or respiratory arras shock, or heart tailure. List only one cause on each line. Immediata Causa (Final diseasa or condition resulting in death) Doa to (or as a consequence ot): Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or Injury Due to (or as a consequence of): that initiated events resulting in death) Last Dua to (or as a consequence of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown ear 24a. Was an autopsy 24b. Wara autopsy tindings available prior to completion of causa of death? 1 Yes 2000 1 Yes 2 No 25. Was casa reterrad to medical 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

The law requires that the death certificate be assecuted P.O. Box 68760, Division of Vital Records, To the Hospital or Attending Physician: the funeral director. After this

Physician/Medical Examiner Medical Certification: To Be Completed by

3 Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of config

31. Date filed (Month, Day, Year)

SEP

**Physician** 

Examiner

**Funeral** 

**Director** 

28a-f show

6 23a

item 27 is marked other than "natural", or item other traumatic event, the Medical Example.

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permit. Pages 1 and 2 Depertment of Health a Important: If Itam 27 Is eny Injury or other trai

**Physician** 

/Medical Examiner

Maryland 21215-0020

Baltimore,

Matthews,

Directo

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Be Completed

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State Registrar

1 4 2000

6 Could not be detarmined

SIZIA

28e. Place of Injury - At home, tarm, streat, factory, office building, etc. (Specify)

29c. Licansa number 005

15. Certifying Phyatclan: To the best of my knowledga, daath occurred at tha tima, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Date signed (Month, Day, Year)

28t. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who

32. Registrar's Signature

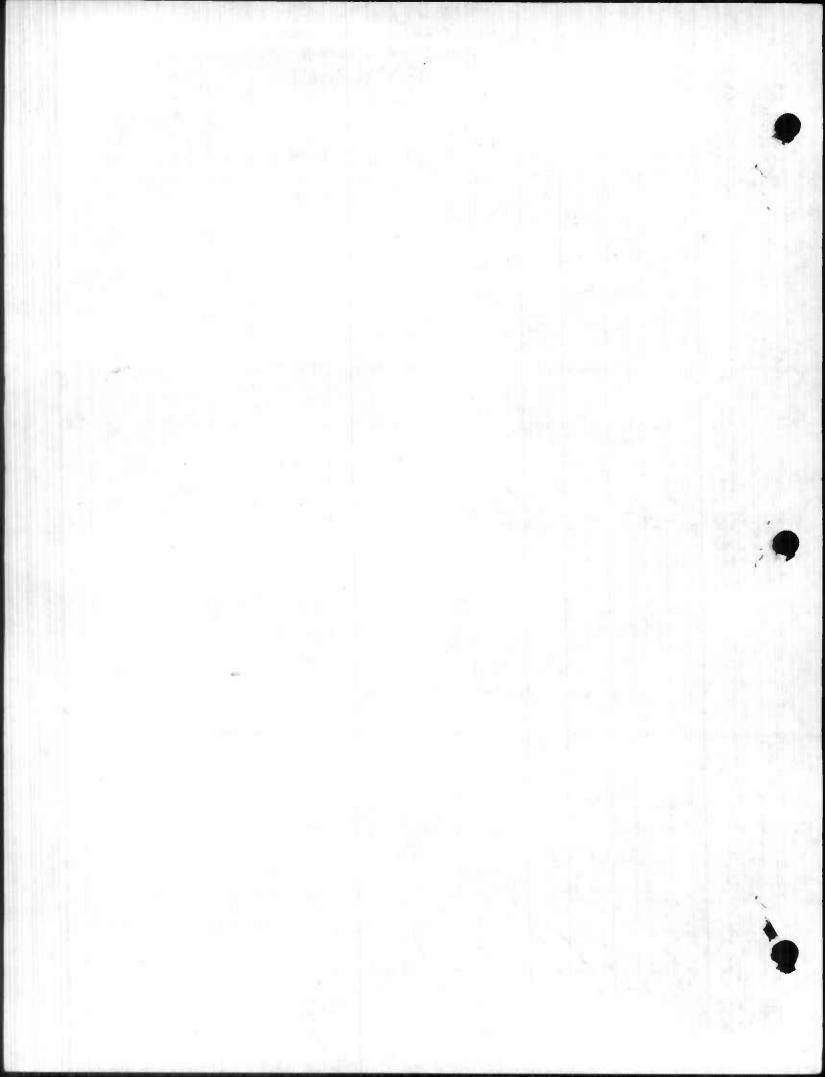
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	State of Maryland / Departmen	t of Health and Mental Hygiene

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	Funeral		Sex 120 M 2□ F	7. Age (In yrs.	last birthdey Yrs.	Months D	eys Ho	Under 24 Hrs. ours Min.	8. Dete of B (Month, D	irth lay, Year)		ece (Stete or Foreign
	Director	Usuel Residence of Decedent		39	113.				AUG 9,	1960	Penns	yl.vania
	No.	10a. Steta 10b. County		10c. Cit	y, Town or L	ocation					10	d. Inside City Limits
	Man Hed	Maryland Cecil		El	kton							1 ☐ Yas 2X No
	with the Marylar a or 28a-f show be notified at Director	10e. Street and Number				10f. Zip Co	de	801	10g. Citizen ot What Country?			ry?
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/lai	should be not Mental nametic eve To Be	Howard Madden					E	Elizabe	th Boy	Ē		
Maryland 21215-0020	2 sho and is ma	19e. tnformant's Name/Reletionship			19b. Mel	ling Addrass (Si	treet end I	Number or Rui	ral Route Num	ber, City or Tow	n, Stete, Zip (	Code)
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Baltimore,	Pages 1 nant of H int: If ite ary or off	20e. Method of Disposition 1 ☐ Buriel 2 【Cremetion 3 [	☐Removel trom	Stete	cemetery, cre	position (Neme of emetory or other plece)			Dete		- City or Tov	
E E	timen tamt: (jury	4 □ Donation 5 □ Other (Speci		R.		ris & C				West C	hester	, PA
Bal	permit. Pa Departmen Important: any Injury arice.	21. Signature of Fundal Salva London  22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21										
		23 Clarter Enter the disease, or con shock, or heart failure. List only	They	w								Approximata
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760,	e be exe sician a e burial-	Sequentially list conditions, it eny, laeding to immediate cause. Entar Undartying Cause (Disaase or Injury	c									
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0	the death certifical ed by the attending phy detached for use as the physician/Medi	Pert II. Other eignificant conditions	contributing to de	eath out not res	uiting in the	underlying caus	e given in	Peπ I.				the cause of death?
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Division of Vital Records, P.O. Box 68	The law requires that the death certifica rate has been signed by the attending phy. page 2 should be detached for use as the completed by Physician/Med		23%	4		4			24e. We	s an autopsy formed?	eva	re autopsy tindings ilable prior to appletion of cause leath?
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Divis	** Hospital or Attending Physician; n 24 holiza ster death. ** Funeral Director: After this certifical hately filled in by the funeral director, edical Certification; To Be (	3 Suicide 6 X Could not l	200. Flaca	of Injury - At he ng. etc. (Specif d: reside	ome, ferm, s	treet, fectory, of	ffice		281. Location City or To Road Ris	(Street and Number (Street and Number State) 6: Sing Sun,	South Mary Lan	Routa Number, Fieldcrest
77	Hospita 24 hours Funeral blately filled	29a, Cartifiar (Check only one)  1 Certifying P 2 Medicat Exa	miner: On the ba	best of my kno asis of examina ner stated.	wiedge, des tion and/or i	th occurred et ti nvestigetion, in	he time, di my opinio	ate end plece n, deeth occur	, end due to the rred et the time	e ceuse(s) end a, data and plac	menner as ste e, and due to	ated. the cause(s)
_	1	29b. Signeture end titla of certitier 29c. License number 29d. Dete signed (Month, Dey,									Dey, Year)	
	V	1	110	1. M	D.		0.C.			Au	igust 2	2, 2000
-	Por	30. Neme and eddress ot person who	complated caus	se ot death (Item	n 23a) (Type	, Print)	71-1					
	) ()	MARY G. 31. Dete filed (Month, Day, Year)	RIPPL	E,M.1	/. 111	Penn St	treet	, Balt	imore,	Marylan	d 2120	1
	State Registrar	30. Name and eddress of person who MARY G. 31. Deterflied (Month, Day, Year) SEP 1 4	2000	Supplied to Signal	par /	B A	oork	3				

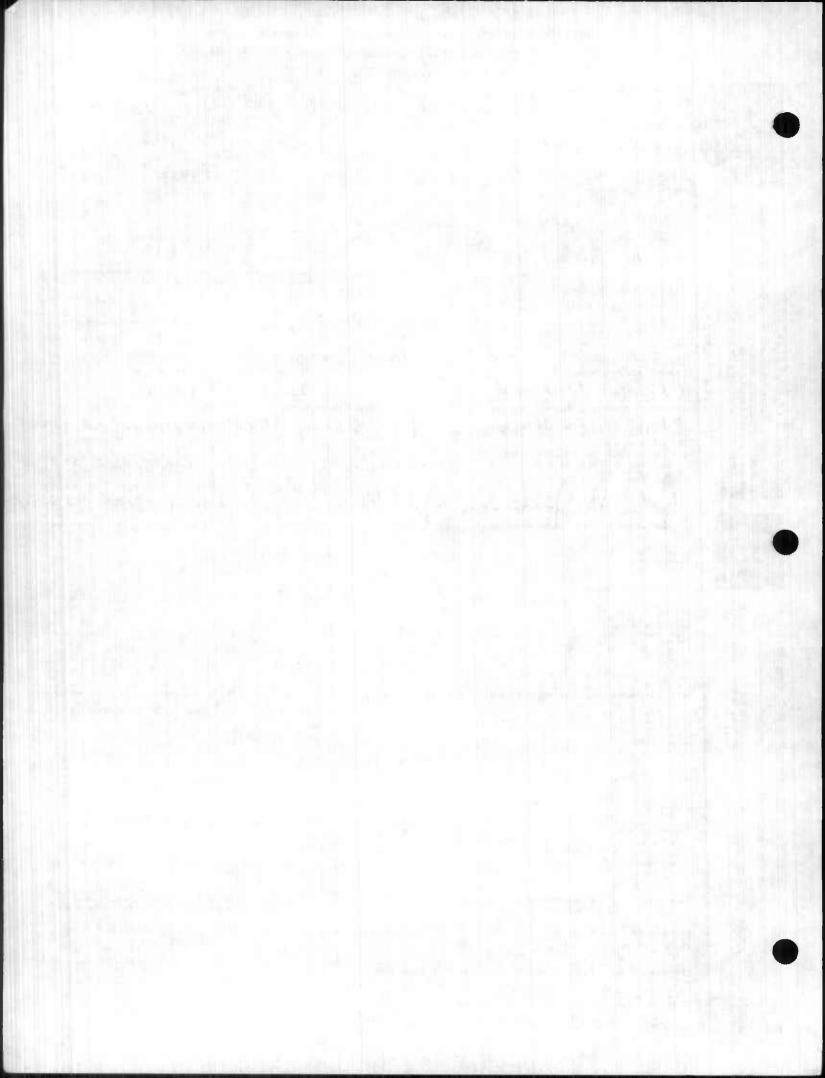
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 00 29050

_				Cen	tificate of Death	R	eg. No.	
	Physicia	an I	1. Decedent'a Name (First, Middle, Last)	И.	McLeod	2. Dale of Deal Month	Day Ye	
	/Medic		4a Facility Name (If not institution, give street and number)			r Location of Death	4c. County of E	
	Examin	er	111 N. Carey Street	Apt 3	Ra 14	)	NA	
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year If Under 24 Hi		9.	Birthplece (State or Foreign
П	Director		216-20-8760 10M 2XF 78	Yrs.	Months Days Hours Mi	1. (Month, Day, 5-15-	1922	Country) S.C.
	2 .		Usual Residence of Decedent  10a. State 10b. County 10c. Ci	ty, Town or Loc	cation			10d. Inside City Limits
	Re-f sho	Director	Md NA B.	altin	noie			16 Yes 2 1 No
	th with the Maryt 23s or 28s-f sho ust be notified at	al Dire	10e. Street and Number 111 N. Carey St Apt	3	101. Zip Code 2-1223		Og. Citizen of Whe	^
	r dea	Funeral	11. Marital Slatus 12. Was Decedent Ever in U		Vas Decedent of Hispanic Origin? Yes, specify Cuban, Mexican, Pue	Specify Yes or No- into Rican, etc.)		American Indian, Vhita, etc.
5-0020	ours arts raf, or R Examin	ò	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1	☐ Yes 2 No Specify:		Specify:	Black
5-0	72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usuel Occupation kind of work done during most of w		16b. Kind of Busin	
121	Pan Pan	du	Elementary/Secondary (0-12) College (1-4or 5+)	life. D	OO NOT use retired)		M	Baltimore
d 2	Hygie Hygie	00	17. Fether's Name (First, Middle, Last)	1 14	ouse Keeping	ame (First, Middle, I		l Huspital
lan	d be and o	To Be	Charles McLeod		Days	MI	roman	
ary	shoul mark mark	F	19a. Intormant's Name/Relationship (Type, Print)	19b. Mailing	g Address (Street end Number or	-		te, Zip Code) Apt 3
×	24.00		Elvin Edmonds - Son	111 1	V. Carey S.	treet 13	Baltimo	e, nd 21223
ore,	them the company			Place of Dispos	sition (Neme of netory or other place)		20c. Location - Cit	
Ĕ	Page mention my or		1 Liburier 2 Extremation 3 Lihemoval from State / /	ween	1	9-13-00	Baltin	nore, orl
Balt	Depart Import any in		21. Separature of Funeral Service Doensee	一光	Name end Address of Facility U	lest	· · · · · · · · · · · · · · · · · · ·	alto, Md Zizis
			23a. Furt. Enter the disease, or complications that caused the deal	h. Eo not ente		sh Aves ac or respiratory err	1 -1	Approximate
	Ph sician							Interval Between Onset and Death
М	/Medical		Immediate Cause (Final disease or condition	mui	occardial in	forcha	. ~	
п	Examiner		rasulting in death)  Due to (c	or as a consequ	occurding (no			
-	D 15	edical Examiner	cons	estin	e reat fo	ilone		
	icate be executed physician and s the burial-transit	хал	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse, (Disease or injury	br as a consequ	uenca of):			
9	be a sician buris	alE	cause. Enter Underlying Ceuse (Disease or injury that initieted events	tens	LON			i
68760	entificate ding phys		resulting in death) Last	or as e consequ				
×		2	d. Corona	m,	ontery dis	ise		
. Bo	the atter thed for a	Sicia	Part II. Other significant conditions contributing to deeth but not res	sulting in the un	nderlying cause given in Part I.	23b. Dld to	obacco uss contri	bute to the cause of death?
P.0	ires that the death or signed by the attent d be detached for un	Physician	Penal forture			1 D Y	88 2 No 3	Probably 4 Unknown
	the se	by	100,000 100.00			-	-	
Records,	The law requires ate has been sign page 2 should be	Completed				24e. Was a perform		4b. Were autopsy findings available prior to completion of cause of death?
	The law te has vage 2	E O				1 🗆 Y	es 20 No	1 Yes 2 No
ta	iclen: The	Bec	25. Was case reterred to medical		26. Place of D	eath (Check only or	10)	
>	Physician: this certific	10	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient	t 3 DOA Other: 4 Nursing	Home 5 Resid	enca 6 Other	Specify)
0	ther th	on:	27. Manner of Desth  1 ☑ Naturel 5 ☐ Pending 28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. tnjury at Work?	28d. Describe h	ow injury occurred	
Sio	Attending or death.  ector: After by the fune	cati	2 Accident Investigation 3 Suicide 6 Could not be	41 6	M 1 Yes 2 No			
Division of Vital	or Att	Certification:	4 Homicide determined 28e. Plece of Injury - At h	ome, term, stre	set, factory, office	28f. Location (S City or Town	treet and Number ( n, Stete)	or Rural Route Number,
	pital pours filled	ğ	29a. Certifier V Certifying Physician: To the best of my kno	awledge deeth	occurred at the time, date and ale	os and due to the c	auca/c) and mann	or ac eteled
	Hos 24 h Fun letely	edicai	(Check only one)  2 Medical Examiner: On the basis of exemine and manner stated.	ation and/or Inv	restigetion, in my opinion, death or	curred et the time, d	ate end piece, end	due to the cause(s)
	To the Mospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Ž.	29b. Signature and title of certifier		29c. License number	2	9d. Date signed (/	Month, Dey, Year)
	0		1 JMK dushi		D38046		91 (31	00
	13		30. Name and address of person who completed cause of death (Item	m 23a) (Type, F		14	12.51	
			JMIKovski, 1000 car	redu	X Street Ba	TOWN C	101	
	Stat	e	31. Date filed (Month, Dey, Year) 32. Registrar's Sign	ature /	ne Ka			

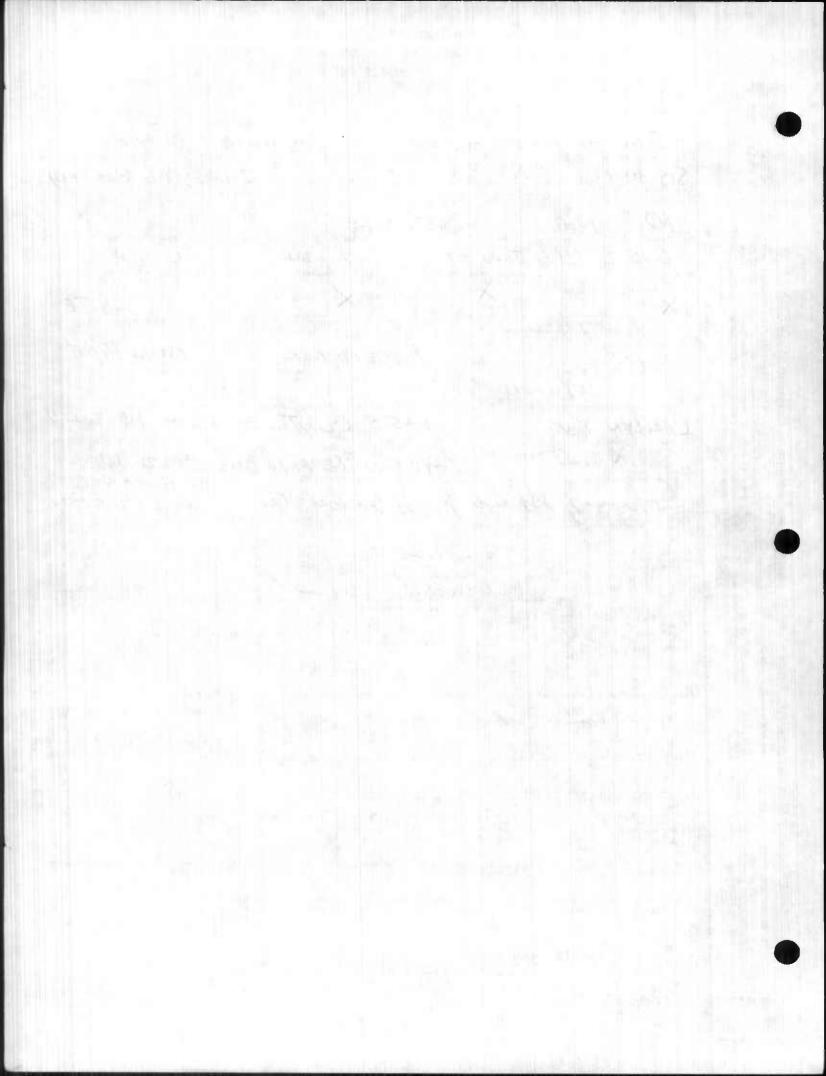
DHMH 16 Rsv 6/95



State of Maryland / Department of Health and Mental Hygiene 00 29051

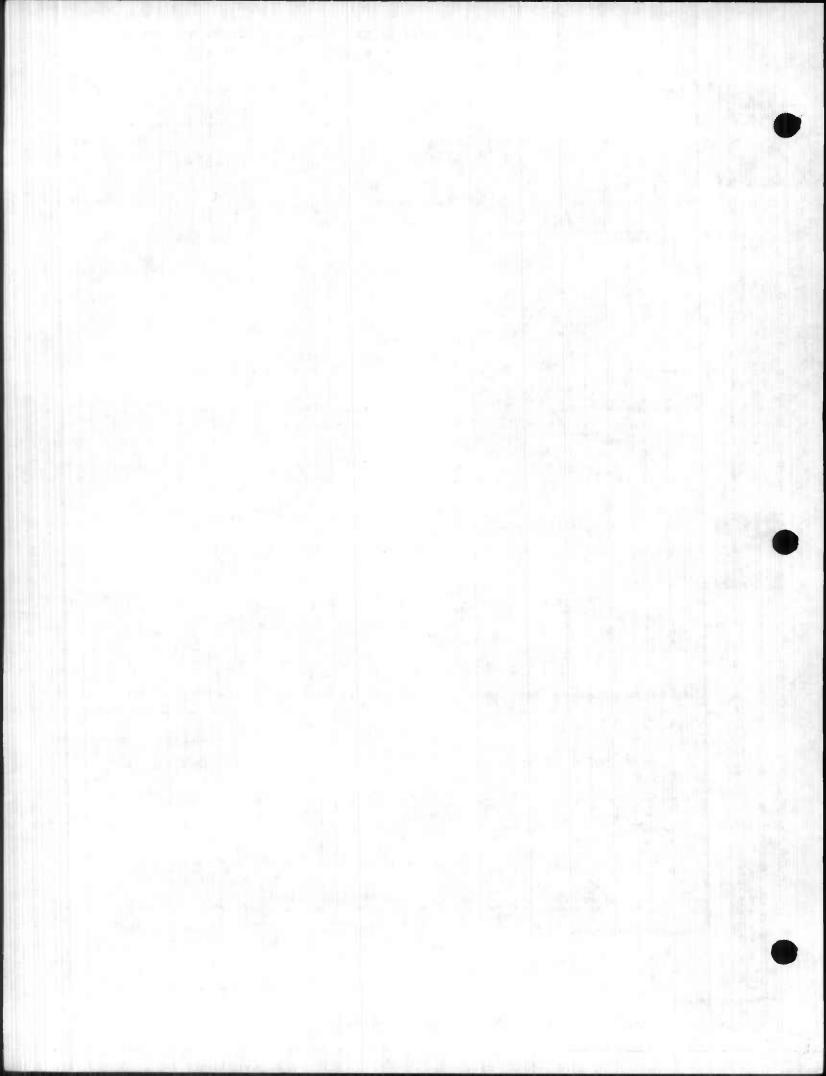
				Certificate	of Death		Reg. No.	- Luc -	001				
		1. Decedent's Nama (First, Middle, La	3. T	ime of Death									
	Physician	LUISE MO	Month	Day 10	Year //	1:00 15							
	_/Medical	4a Facility Name (If not institution, give	Con 19 Ly		4b. City, Town, o	Location of Deal			14.				
	Examiner	T 11 11	11	i 1	0		AC. County	)/1					
		JOHN HODI	KINS BAYV.		1 1 1 1	MORE		111					
	Funeral	5. Social Security Number / 6. 5		Months	1 Yaar If Under 24 Hr Days Hours Mir	. (Month, D	rth sy Year)	9. Birthplace (S Cauntry)	Stete or Foreign				
	Director	515-34-0376 10 M 2XF 83 Yrs. Months Days Hours Min. TUNE 6 1917 CERMINAL											
	ther death with the Manyland Thems 23s or 23s-f show sinst must be notified at Funeral Director	Usual Rasidence of Decedent											
0		10a. State 10b. County 10c. City, Town or Location											
		BALTIMORE											
		10e. Street and Number 10f. Zip Code 10g. Citizen of Wha											
		600 D. CE			21224								
	S HI DI	11. Marital Status	12. Was Decedent Ever in U, Armed Forces?	S. 13. Was Decede It Yes, speci	ent of Hispanic Origin? ( ify Cuban, Mexican, Pue	Specify Yes or Norto Rican, etc.)	o- 14. Raci	a - American Ind k, White, etc.	ian,				
	書 2番 正	1 Never Married 2 Married	1 Yes 2 No		1 ☐ Yes 2 No Specity:								
5-0020	D Est	3 Widowed 4 □ Divorced	Year or Datas:	13100 1	Cho opposite		Specify	IE					
3	ed within 72 ho ygiene. we then "neture it, the Medical Completed	15. Decedent's E	ducation	16a. Decedent's Usual	Occupation		16b. Kind of Bu	siness/Industry	s/Industry				
27	ple ple	(Specify only highest grant   Elementary/Secondary (0-12)		life. DO NOT use	k dona during most of w e retired)	orking							
27	the the	Lienteritary/secondary (0-12)	College (1-4or 5+)	HOME !	MAKER		OWN	J HOM	E				
D 2		17. Fathar's Name (First, Middle, Last	)	11011121		ame (First, Middle	, Maiden Surnam						
급	B we de	1/	s ewo				PACELLO						
3	To To					V							
lar	the series	19a. informant's Name/Relationship (	Type, Print)	19b. Mailing Address	(Street end Number or F	Rural Route Numb	er, City or Town,	State, Zip Code) 40. ZVZZ4					
2	242	CAROLYN KU.	5	625 5.	CLINION	ST. 12	ALTO. 1	MD - W	224				
a.	- X = 6	20a. Mathod of Disposition	1 4	Place of Disposition (Nem	e of her place)	Date	20c. Location -	City or Town, St	late				
St.	y or a	1 Burial 2 Cremation 3 5		7301 m	BOLTO UD.								
₫	and and	21, SignetUre of Furneral Service Lice	1	22 Name and	Address of Facility	1000	PATHO	. 100					
Ba	E de la de	7,0	10 00	22. Ivalillo allo	Address of Facility	32	2/8 HUD	30 201					
0	2020	Tromany.	ARaida X	HOFFN	PRUN JKA	PDA 1	BALTO.	MD-21	224				
	Physician /Medical Examiner	23a. Part1. Enter the disease of com	plications that caused the death	h. Do not enter the mode	of dying, such as cardi	ac or respiratory	rrest,	Appro	oximate				
		23a. Part 1. Enter the disease of complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval Between Onset and Death											
퉵		immediate Causa (Final	mon	4									
		disease or condition resulting in death)	a	7000				11.010	45				
		Due to (or as a consequence of):											
	Parit ed												
	icate be executed physician and s the burial-transit	Sequentially list conditions. Due to (or as a consequence of):											
30,	rian Li												
68760,	ertificate be executed fing physician and e as the bural-transit Medical Examir	Cause (Disease or injury C											
	eath certifice attending pld for use as t	resulting in death) Last											
XO	nding use a		d					1					
Bo	death e atter ed for u	Day II Other standings and distance		age Die	auga of death?								
0	by the ache	Part ii. Other algnificant conditions of	contributing to death but not res	uiting in the underlying ca				Beebahly 4 17 to known					
P.0		Hy pertersin	Diabetis		1	Yas 2 No	3 Probably	Probably 4 Unknown					
Ś	signed of be del								autana tindina				
Records,	The law requires are hes been sign, page 2 should be Completed by					24a. Wa	s an autopsy ormed?	available	autopsy tindings ole prior to				
S	aw re 2 sh 2 sh					on of cause							
Œ	The law ite has to page 2 s				10	Yes 2 No	1 ☐ Yes	2 No					
a	ystcian: The I is certificate he director, page To Be Com	25. Was case reterred to medical			00 Di4 D		/-	1 100	72.0				
=	Physician: this certific ral director,	examiner?	Hospital:	ER/Outpatient 3X DO	Other:	eath (Check only							
n of Vital	4 53	1 Yes 2 No	1 ☐ Inpatient 2 ☐	er (Specify)									
	After th funeral flon:	27. Manner of Death Natural 5 Pending	28a. Date of injury (Month, Dey Year)	28b. Time of lnjury	e how injury occurred								
Division	To the Hospital or Attending P within 42 hours after death: To the Funeral Director: After to ompletely filled in by the funeral Medical Certification:	2 Accident investigatio		М	1 ☐ Yes 2 ☐ No								
Vis	or Attendiate death.  Director: A d in by the fireficati	3 Suicide 6 Could not be determined	(Street and Numb	mber or Rural Route Number,									
Ö	din din	28e. Place of Injury - At home, tarm, street, factory, offica building, etc. (Specify)											
	within 24 hours are to the Funeral I completely filled												
	he Hospi in 24 hours he Funer pletsly fil	(Check only one)  2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.											
	Me mple	29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year)											
	5 1 5 S	255. Signature and time of certifier		250.	2.		_ Ju. Data algito	( , , , , , , , , , , , , , , , , , , ,					
		11. Juliants	-, ws.		12146v		91	11/00					
	0	30. Name and address of person who					1						
		ROBERT LIRERT	o. mo. 3508	BANKST	BALTO.	my 2	1224						
	State	31. Date (Donn), Day, Yearh	\$2. Registrar's Signa		71,-1-)	1 31	1						
	Donista	OF1 T 4 (000	Deniva	D Ann	Wall Comments								

DHMH 16 Rev 6/95



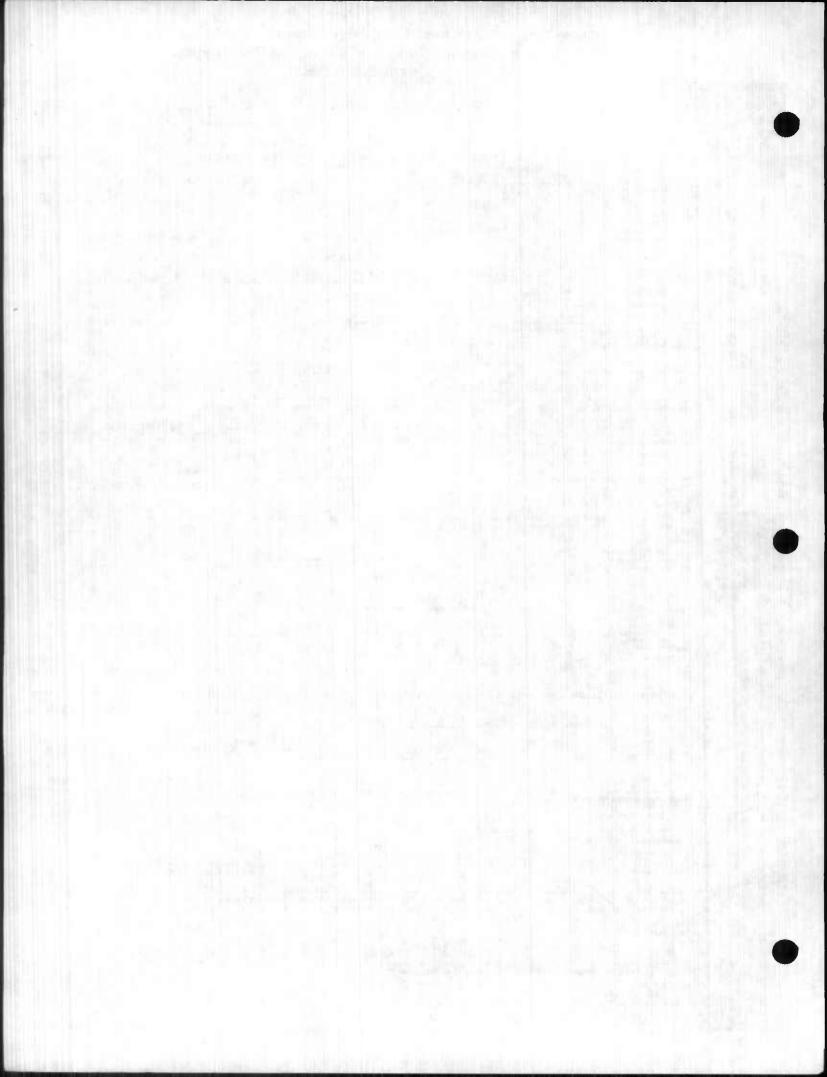
State of Maryland / Department of Health and Mental Hygiene 00 29052

			C	ertificate (	of Death		Reg. No.					
Dhusisian	1. Decedent's Nama (First, Middla, Last					2. Data of D Month	eath Day	3. Time of				
Physician /Medical	Ruth Mary Metroen contemped to some 1-3											
kaminer	4a Facility Nama (If not institution, give	4b. City, Town	n, or Location of Dea									
•	Saint Joseph 1	Center		To	wson	Baltimo						
Funeral Director	5. Social Security Number 6. Se		ga (In yrs. last birtho	day) If Under 1 Y			irth	9. Birthpiaca (State of Country)				
	214-24-5686	□M 212 F	73 Yr	s. Months D	ays Hours	Min. (Month, D	12,1927	Maryland				
-	Usual Residence of Decedent											
	10a. Stata 10b. County 10c. City, Town or Location											
to	Maryland Baltimo	re	1	Baltimore	2			1 ☐ Yes				
thems 23a or 28a-1 siner must be notified.	10e. Street and Number	-		10f. Zip Co	de	10g. Citizen of V	10g. Citizen of What Country?					
	4 Lona Court		21236	,	U.S.A.							
	11. Marital Status	12. Was Decedent	Ever in U,S.	13. Was Decedent	of Hispanic Origin	n? (Specify Yas or N Puerto Rican, atc.)	No- 14. Race - American Indian,					
2	1 ☐ Nevar Married 2 🔀 Married	Armed Forces' 1 ☐ Yas 2 💢	No			Puerto Rican, atc.)						
by	3 Widowed 4 Divorced	If Yas, Give Year or Dates:		1□ Yas 2风	No Specify:	specity: White						
per	15. Decedent's Edu	ıcation	16a. D	ecedent's Usual O	ccupation		16b. Kind of Bu	usiness/Industry				
ple	(Specify only highest grad	le completed) College (1-4or	( ( )	Give kind of work dife. DO NOT use r	one during most o etired)	of working						
Completed	12th Grade		Own Home									
Bec	17. Father's Nama (First, Middla, Last)				18. Mother's	r's Name (First, Middle, Maiden Sumeme)						
ToB	Michael J. Fri	esner			Edno	r King						
F	19a. Informant's Name/Relationship (T)	(pe, Print)	19b. A	Aeiling Address (S	treet end Number	or Rurel Route Numi	ber, City or Town.	Stete, Zip Code)				
	19a. Informant's Name/Relationship (Type, Print)  Mr. Albert T. Metzger (husband)  19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)  4 Lona Cowrt, Baltimore, MD 21236											
	20a. Method of Disposition	3	20b. Place of D	Disposition (Neme of	of	Date						
	1 X Burial 2 ☐ Cremation 3 ☐ F		cemetery,	cremetory or other	r plece)	0/15/00						
	4 Donation 5 Other (Specify) Moreland Memorial Park 9/15/00 Baltimore,											
8	21. Signature of Funeral Service Licensee (22. Nama and Address of Facility Schimune Funeral Home, Inc.											
	Nrishna L. Dand Schimunek Funeral Home, Inc. MD 21236											
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval Between											
ın								Onset and				
1	Immediata Cause (Final ACUTE RESPIRATORY DISTRESS SYNDROME 3 WEE											
	disease or condition resulting in death)  Bue to for as a consequence of:											
je 🔳	Due to (or as a consequence of): PNEUMONIA											
Examiner	Sequentially list conditions  Due to (or es a consequence of):											
W X	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury C.											
edical	Cause (Disease or injury that initiated events Dua to (or as a consequence of):											
	rasulting in death) Last Dua to (or as a consequenca or):											
3												
Icla	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco uss contribute to the cause of											
Physician	- a.t.n. ourse argumount conditions col											
d by	24a. Was an autopsy							24b. Were autopsy find				
ete		par	formed?	available prior complation of								
Completed								of death?				
						10	Yes 20 No	1 ☐ Yes 2 ☑				
Be	25. Was case referred to medical exeminer?	one)										
10	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other											
5	27. Menner of Deeth 1 ☑ Netural 5 ☐ Pending	28a. Dete of Inj (Month, De	ury 28b. Tin	ne of 28c.	28c. Injury at Work? 28d. Descri			ribe how injury occurred				
atic	2 Accident investigation	1 Yes 2 N										
tific	3 Suicide 6 Could not be determined	28f. Location City or To	28f. Location (Street and Number or Rurel Route Number City or Town, Stete)									
Certification:	3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)											
	29a. Certifier 12 Certifying Phys	sician: To the best	of my knowledge, o	leeth occurred at t	he time, date and	place, and due to the	e cause(s) and ma	anner as stated.				
Medical	29a. Certifier  **Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.  **Check only one)**  **Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.  **Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.  **Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.											
Me	29b. Signature and titla of certifier 29c. Licansa number 29d. Date signed (Month, Dey, Year)											
	m		9-12-2000									
	30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)											
					TOLIC	ON MARY	I OND O	2004				
	FRANCIS KHOO, 1		501 DSLE	וא ואון אי	-, IUWS	DN, MARY	LHND 21	1204				
tate	31. Date filed (Month, Dey, Year)	1	rar's Signatura	1	.2							
trar	SEP 1 4 2000	Dens	wa &	spar	63							



State of Maryland / Department of Health and Mental Hygiene 0 29053

	Certificate of Death								Reg. No.				
Physician /Medical	1. Decedent's Name (First, Middle, Last)  Robert Douglas Metcalf, Sr.								2. Dete of Death Month Day Year September 6 2000 10:10 A.M.				
Examiner	4a Facility Neme (If not institution, give street and number) 19 E. Ostend Street						4b. City, Town, or Location of Do Baltimore						
Funeral Director	226 62 6076	Sex 1 M 2□F	7. Age (In yrs. las 54	Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, De April	rth ey, Year) 24, 1946	Coun	lace (Stete or Foreign try) /land	
tarytand show adat	Usual Residence of Decedent  10a. Stete 10b. County  Maryland N/A		10c. City, Town or Location  Baltimore								0d. Inside City Limits  12€ Yes 2 □ No		
or 28a4 s be notified	10a. Street and Number					Code				10g. Citizen of Whet Country?			
	19 E. Ostend Street 212						80			U.S	U.S.		
020 un after death et, or items 23 Examiner mast by Furneral	3 ☐ Widowed 4 ☐ Divorced	dent Ever in U,S. ces? 2 No e ites:Viet N	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						Blac	14. Race - American Indian, Black, White, etc.  Specity: White			
ad within 72 hours at yours at yours at yours at yours at yours. At the Medical Exam Completed by 1	15. Decedent's (Specify only highest   Elementery/Secondary (0-12)	15. Decedent's Education (Specify only highest grede completed)  Elementery/Secondary (0-12)  College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Supervisor  16b. Kind of Business/In Chemical Co							
and the second	17. Fether's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Meiden Sumeme)  Robert C. Metcalf  Anna V. Raynes												
- 5904	19a. Informent's Name/Relationship (Type, Print)  Mary Metcalf / Wife  19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)  19c. Ostend Street  Baltimore, Maryland 21230  20a. Method of Disposition  19c. Ostend Street  Baltimore, Maryland 21230  20b. Place of Disposition (Name of cemelery, cremetory or other place)												
Saltimore omit. Pages 1. spartment of Ha reportent if Ilen ny Injury or oth	4 Donation 5 Other (Specify) Cedar Hill Cemetery 9/9/00 Baltimore, Maryland  21. Signature of Funeral Service Licensee Concerns Facility Gonce Funeral Home P.A.												
m gossa	23e. Part. Enter the disease, or complications that caused the deart. Do not enter the mode of dying, such as cardiec or respiretory arrest,  Approximate												
Certificate be executed diing physician and use as the burial-transit	Cause (Disease or Injury that initiated events resulting in death) Lest	e	Due to (or a	s a consequ	uence of):	A	INT	(A)	× 1	02	16		
P.O. Bo hat the death of by the atten detached for u	Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t.  23b. Did tobecco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Droknow.												
Record e law requir has been s ge 2 should									perl	s an autopsy ormed?	co	are autopsy findings allable prior to modelion of cause death?	
reician: The secrificate director, pag							26. Place	of Dear	th (Check only	one)			
ng Phys meral di uneral di	1 ☐ Yes 2 ☑ No	28a. Date of	ital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA										
Division of Tothe Hospital or Attending P within 24 hours after death to the Funeral Director. After the completely filled in by the funeral Medical Certification:	3 Suicide 6 Could no determin	200. PIACE	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street end Number or Rural Route of City or Town, State)						al Route Number,				
Divi	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the ceuse(s) and manner as stated.  Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.												
To withing the company of the compan	29b. Signeture and title of certifier  ATTFNDING  29c. License number  A 9 6 4 6						40	29d. Date eigned (Month, Dey, Year)					
1×0/	30. Name and address of person when MAC S.	no completed cause	of death (Item 2	3a) (Type, I	Print)	14	7	S.	HAn	OVEN	57.		
State Registrar	31. Dete filed (Month, Day, Year) SEP 1 4 20	00 32.A	egistrer's Signatur	9	Spa	rks		PH					



29054

Certificate of Death 3. Time of Death 2. Data of Death Month Day 2, Year SEPTEMBER 12, 2000 MATZ 4:07 PM 4b. City, Town, or Location of Death 4c. County of Death TOWSON BALTIMORE If Under 1 Year If Undar 24 Hrs. Birthplaca (State or Foreign Country) Days Hours Min FEB. 1, 1968 MD 10d. Insida City Limits 1 ☐ Yas 2 ₺ No 10f. Zip Coda 10g. Citizen of What Country? 21208 U.S.A. 14. Race - American Indian, Black, White, atc. Was Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuben, Maxican, Puerto Rican, etc.) 1 Yes 2 No Specify: WHITE 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry REPAIRS COMMERCIAL INDUSTRIAL INVENTORY CONTROL SPECIALIST 18. Mother's Name (First, Middla, Maidan Sumama) CAROL **JACOBS** 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 2 STIRRUP COURT - BALTIMORE, MD 21208 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata BALTIMORE HEBREW CEMETERY 9/13/00 REISTERSTOWN, MD 22. Nama and Addrass of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onsat and Death 10 munute Physician/Medical Examiner Cancer to liver and brain Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings Be Completed 24e. Wes en autopsy performed? available prior to completion of causa of death? 2 No t□Yas 2□ No 1 Yes 25. Was casa refarred to medical 26. Place of Death (Check only one) 1 Yas 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) Hospic Medical Certification: To 27. Mannar of Death Injury at Work? 28d. Dascribe how injury occurred Natural 5 Panding invastigation 1 Yas 2 No 2□ Accident 6 Could not be 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, streat, factory, offica building, atc. (Specify) 4 Homloida 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination end/or Investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and menner stated. 29a, Cartifier 29d. Date signed (Month, Dav. Year) 29b. Signatura and titla of cartifier 29c. Licensa number SOI da H. 02625

**DHMH 16 Rev 6/95** 

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Director: After this certific d in by the funeral director,

filled in by or A ster

death.

To the Hospital of within 24 hours a To the Funeral D completely filled in

of Vitai Records,

Division Attending

> 31. Data filed (Mooth, Pay, Year) State 2000 Registrar

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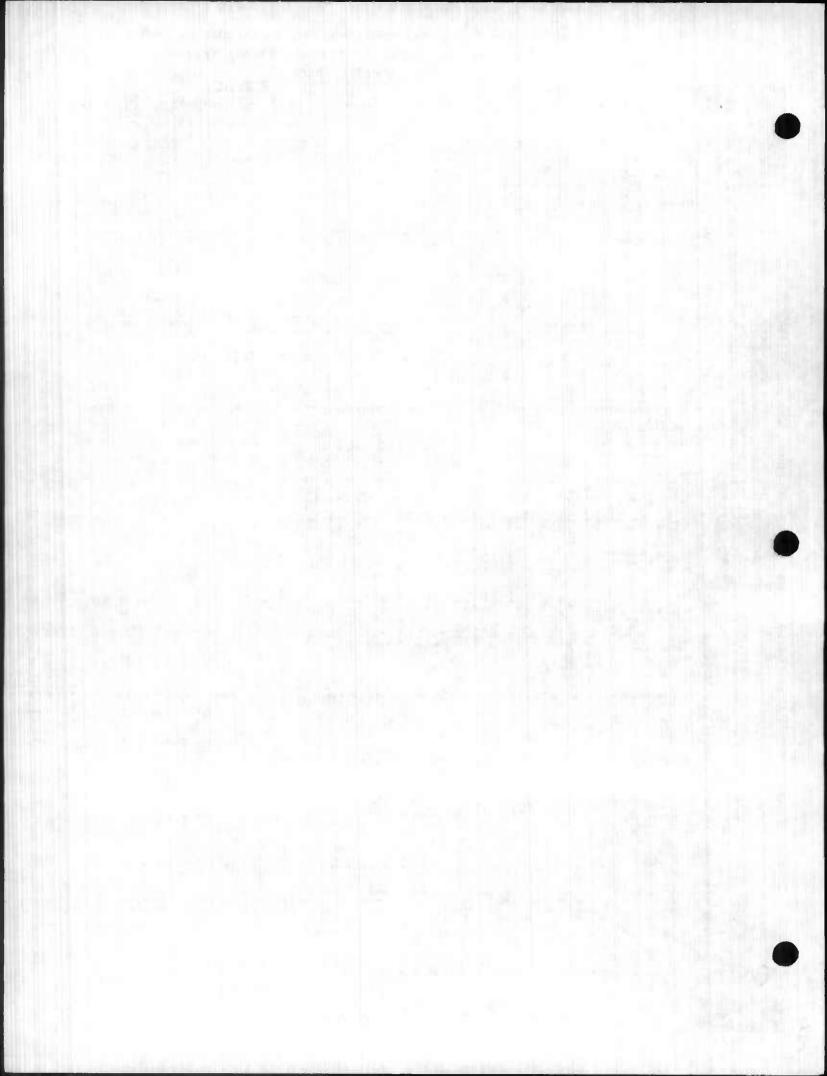
6701 32. Registrar's Signatura

30. Name and addrass of person who completed cause of deeth (Item 23a) (Type, Print)

14-

CHARLES

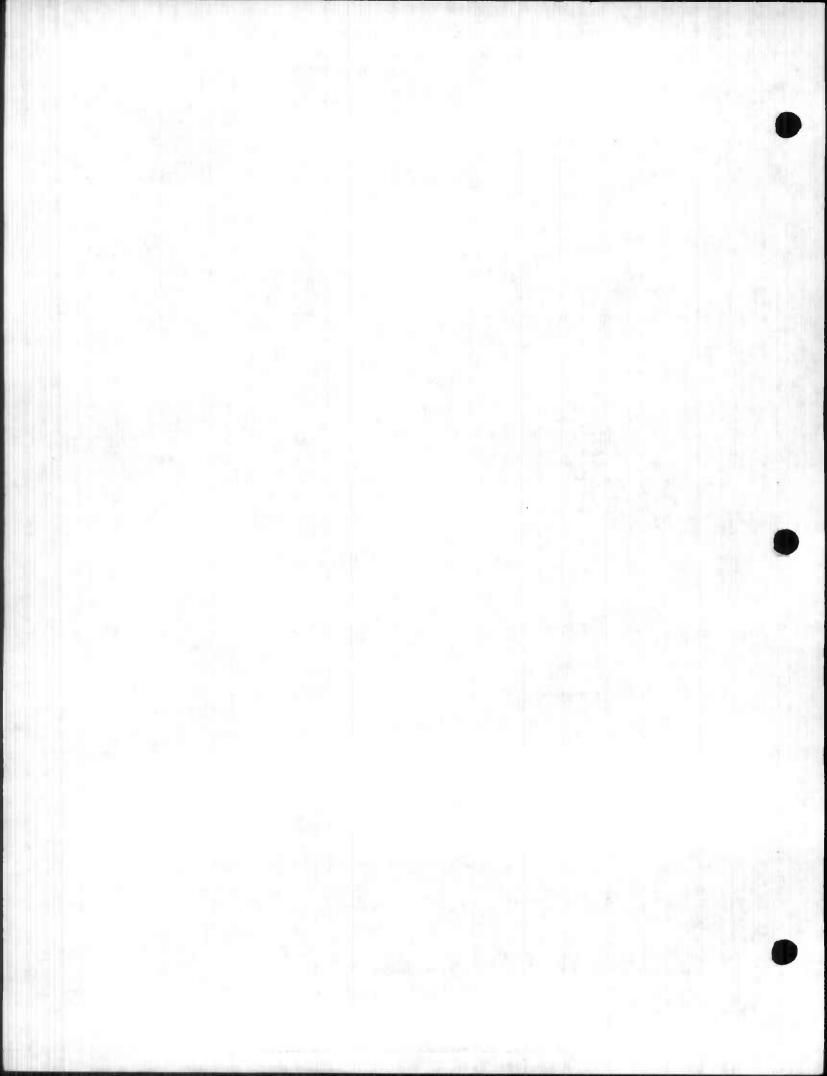
BALTIMORE, MD. 21204



Please Type or Print in Black indelible ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			Ce	rtificate of	Death	F	leg. No.	29055
Dhusisian	1. Decedent's Neme (First, Middle, L	nst)		001		2. Date of Dea Month_		3. Time of Death
Physician /Medical	JOHN	C.		ORLA		SEPTEM	BER 12 2	08:20 PM
Examiner	4a Facility Neme (If not institution, gi	AND DESCRIPTION OF THE PARTY OF			4b. City, Town, or L			
Ser III	GOOD SAMARITI					MORE		N/A
Funeral Director	180-09-3576	Sex 7. Age (in yn	s. last birthday)	Months Deys		8. Dete of Birth (Month, Day Sept 14	Year) , 1913 R	9. Birthplace (State or Foreign Country) Reading PA
P .	Usual Residence of Decedent  10a. State 10b. County	100 (	City, Town or Lo	nontino				10d. Inside City Limits
e Maryla	Md. N/		Sky, Town or Ec		timore Ci	-		1 X Yes 2 □ No
th with the Mar 23e or 28e-f st and be noutled	10e. Street and Number	Orlando Avenu	ie	10f. Zip Code	21234		United	
1215-0020 within 72 hours after death with the Manyland one. than "netural", or thems 23s or 28s-1 show the Medical Examples and the contract or properties of the properties of the contract	11. Marital Status  1 Never Merried 2 Merried  3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 🌣 No	Hispenic Origin? (Spean, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race Bleck, Specify:	- American Indian, White, etc. White
21215-0 ed within 72 ho ygiene. wr than "neturn rt, tra mad call rt, tra mad call completed	15. Decedent's E		16a. Dece	dent's Usuel Occu	pation	kina	16b. Kind of Bus	iness/Industry
21 en en e	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of work			
N See N	12	2	Tool	& Die Sup				arietta Co.
Be See	17. Father's Name (First, Middle, Las	giuseppi Orl	ando			ne (First, Middle, Antonina	Meiden Surneme, Crisci	
Maryla d 2 should th and Men 7 is marke traumatic	19a. Informent's Neme/Relationship		19b. Meili	ing Address (Stree	t end Number or Ru	rei Route Numbe	r, City or Town, S	itete, Zip Code)
CENE	Evelyn G. Orlando			Orlando		Baltimor	e, Maryla	and 21234
O H P P	20a. Method of Disposition  1 X Burial 2 Cremation 3 I	IBamoval from State	_	osition (Name of metory or other ple Valley Me	1	Dete 9/16/00		ity or Town, State  Maryland
Baltim Semit. Par Departmen Important: any injury once.	4 Donation 5 Other (Special Signature of Funeral Service Lice	STATE OF STATE OF		2 Name and Addr	acc of English			
Balti permit. Departm importar any inju	metin k	niell .	gnu or 5	305 Harf	ord Road			Inc. yland 21214
	23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the de-	ath. Do not en	ter the mode of dy	ing, such as cardiac	or respiretory ar	rest,	Approximate Intervel Between
Physiciań /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. MULTI	ORGA (or as a conse		ILURE			Onset and Death
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58750, icate be arecuted physician and s the burial-transit	Sequentially fist conditions	0.	(or as a conse					
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BOX beath cert attendin for use.		d						
the att	Part fl. Other aignificant conditions	contributing to death but not re	esulting in the u	underlying cause g	iven in Part i.	23b. Did t	obacco uae cont	ributa to the cause of death?
requires that the death centrequires that the death centre hould be detached for use a tending by Physician/M	ACUTE REN	AL FAILUR	RE			10	Yea 2□No	3 Probably 4 Unknown
D S S D							an eutopsy med?	24b. Were autopsy findings available prior to completion of cause of death?
The law ate has be page 2 s	The state of the s					101	es 200 No	1 Yas 2 No
sicien: The centificate lirector, pag	25. Was case referred to medical				26. Place of Dee	th (Check only o	ne)	
Nysician: hysician: his certific I director, To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospitel: 1 (Inpatient 2)	☐ ER/Outpatie	nt 3 DOA O	ther		lence 6 DOther	r (Specify)
Ph a Ph	27. Menner of Death  1 Netural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inju			now injury occurre	
DIVISION of all or Attending P is after death.  In Director: Attented in by the funare Certification:	3 Suicide 6 Could not determined	De Con Dinne of John As		reet, fectory, office		28f. Location (S City or Tox	Street end Numbe m, Stete)	r or Rurel Route Number,
To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After complately filled in by the fur.  Medical Certification	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my kr miner: On the besis of examin	nowledge, deet netion end/or in	th occurred at the threat the threat	time, date and place opinion, deeth occu	, and due to the cred et the time,	ceuse(s) end man	ner as stated. nd due to the ceuse(s)
the mpla	29b. Signature end title of certifier	end manner stated.		29c Licer	nse number		29d. Date sinned	(Month, Dey, Year)
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Registrar	SEP 1 4 200	1						



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#2 perPHYG788 10/10/2000 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** September 12000 6 devoid 8:55 AM /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Examiner Columbia, Hary 5400 Vastogs Pt. Road House If Under 1 Yeer | If Under 24 Hrs. | Date of Birth | Months | Days | Hours | Min. (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. ast birthday) Birthplace (State or Foreign Country) **Funeral** 10M 20 F Months Days 76 215-16-1193 Beltinine, Maryla **Director** Usual Residence of Decedent Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f short the Wadical Examiner must be notified at MD Clarksville 1 Yes 2 No Howard Director the 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? with 12248 Summer Sky Path 21029 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - American Indien, Black, White, etc. 72 hours efter 1 Never Married 2 Married Specify: White le merked other than "natural", or Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: 3 Widowed 4 Divorced à WWII Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "neay Injury or other treumatic event, the Med Boce. Elamantary/Secondary (0-12) College (1-4or 5+) clerk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) John G. Parr Lydia G. Pennington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 19e. Informant's Name/Relationship (Type, Print) Christopher P. Parr/son 12248 Summer Sky Path Clarksville, MD 21029 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Sarvice Licansae 22. Name and Address of Facility Wan Sant Joseph State Anatomy Board 655 W. Baltimore Street 23a. Parti. Entar the diseas shock, or heart failure. Baltimore, MD 21201 isease or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, illure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in daath) Examiner Due to (or as a consequence of) Examiner that the death certificate be executed ettending physicien end for use as the bunel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as e consequence of): Physician/Medicai that initiated events resulting in death) Last Due to (or as e consequence of) 98 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? the deteched signed by t 1 Yes 2 70 3 Probably 4 Unknown by The law requires 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy peen completion of cause of daath? has page 2 2 300 1 ☐ Yes 2 ☐ No certificate 1 Yes Physicien: funeral director, Be 25. Was case referred to medical examiner? 26. Placa of Daath (Check only one) Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred Certification: 1 Natural 2 Accident or Attending 5 Pending 1 Yas 2 No investigation 6 Could not be datarminad 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide

Tip Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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32. Ragistrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760, 24 hours efter death.

Funeral Director: After filled in by Hospital completely within 2 the

> State Registrar

edicai

29a. Cartifier

(Check only one)

29b. Signature and titla of certifier

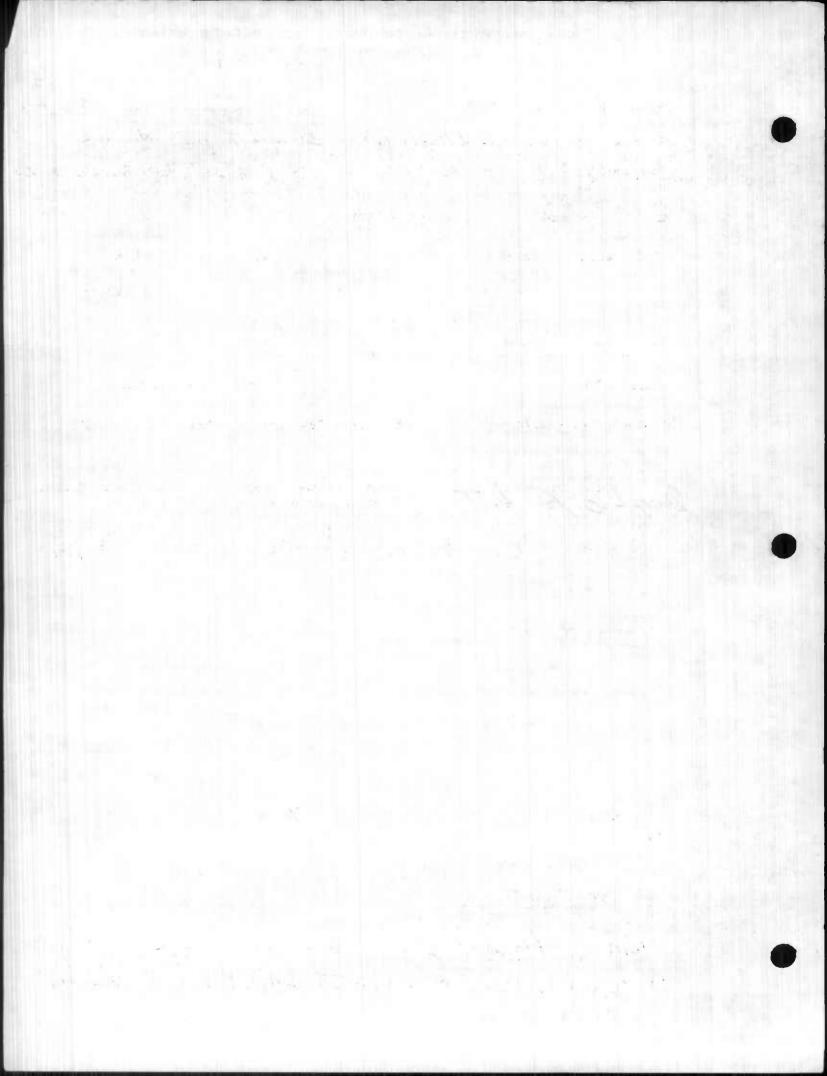
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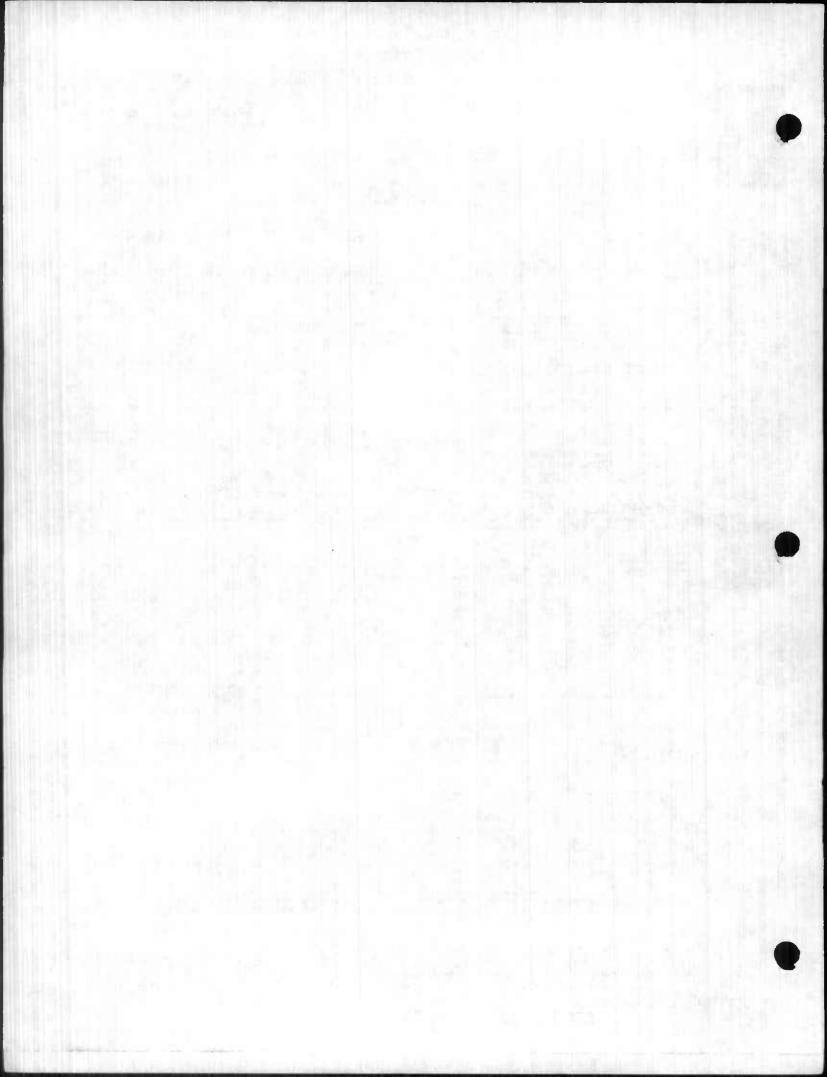
30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print)

2000



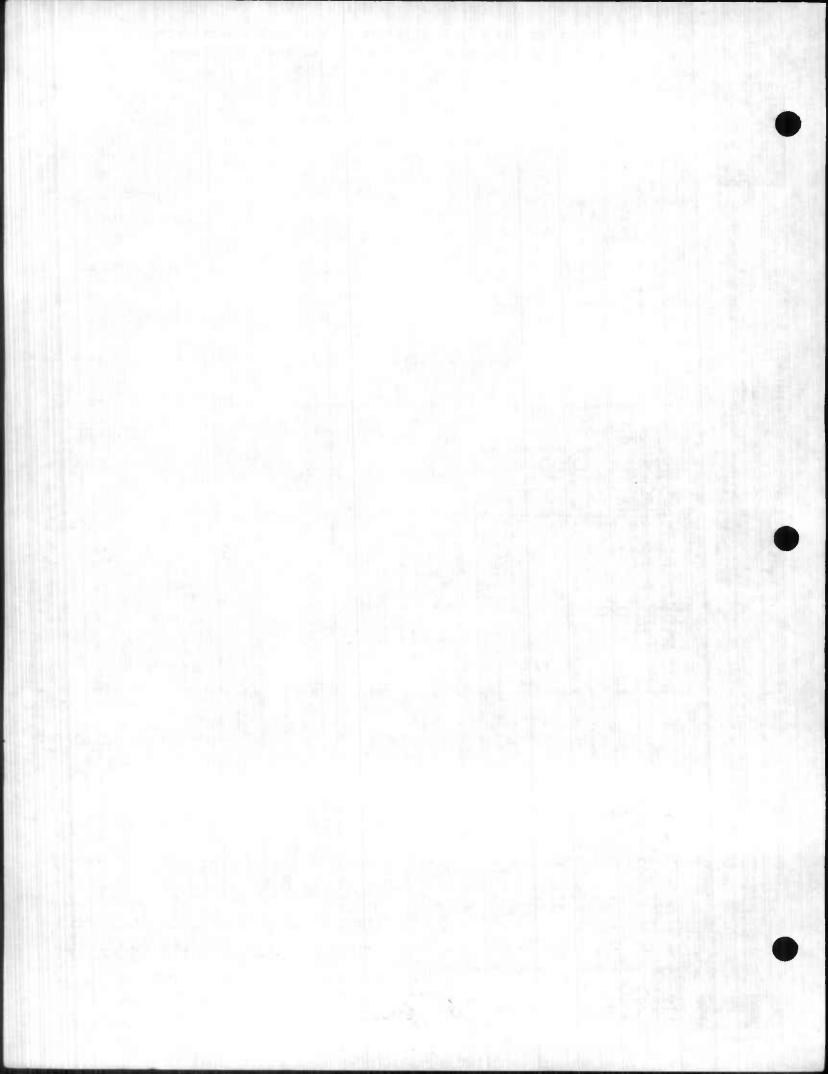
State of Maryland / Department of Health and Mental Hygiene

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P Pe	15. Decedent's Ed	lucation	16a	. Decedent's Us	uel Occupa	ation			16b. Kind o	of Business/	Industry	
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event, Be C	17. Father's Neme (First, Middle, Last)					18. Mother	s Name	(First, Middle	e, Maiden Sun	name)		
and Menial Hygiene. In marked other than "natural", or items 23e or 28e-f show aumstic event, the Medical Exeminer must be notified at To Be Completed by Funeral Director.	Howard Edwards						Alve	erta Wi	neeler			
anne	19e. tnforment's Neme/Reletionship (7	Type, Print)	195	o. Melling Addre	ss (Street e	end Number	or Rure	Route Numb	ber, City or To	wn, State, 2	Zip Code)	
the the	Dorothea Bennett/	sister	2	232 Stor	ecrof	t Rd	#A	Balti	imore,	MD 2	1229	
ry or othe	20e. Method of Disposition  1	Removel from State	20b. Plece o	of Disposition (N ary, cremetory of	ame of			Dete	20c. Location		Town, Stel	te
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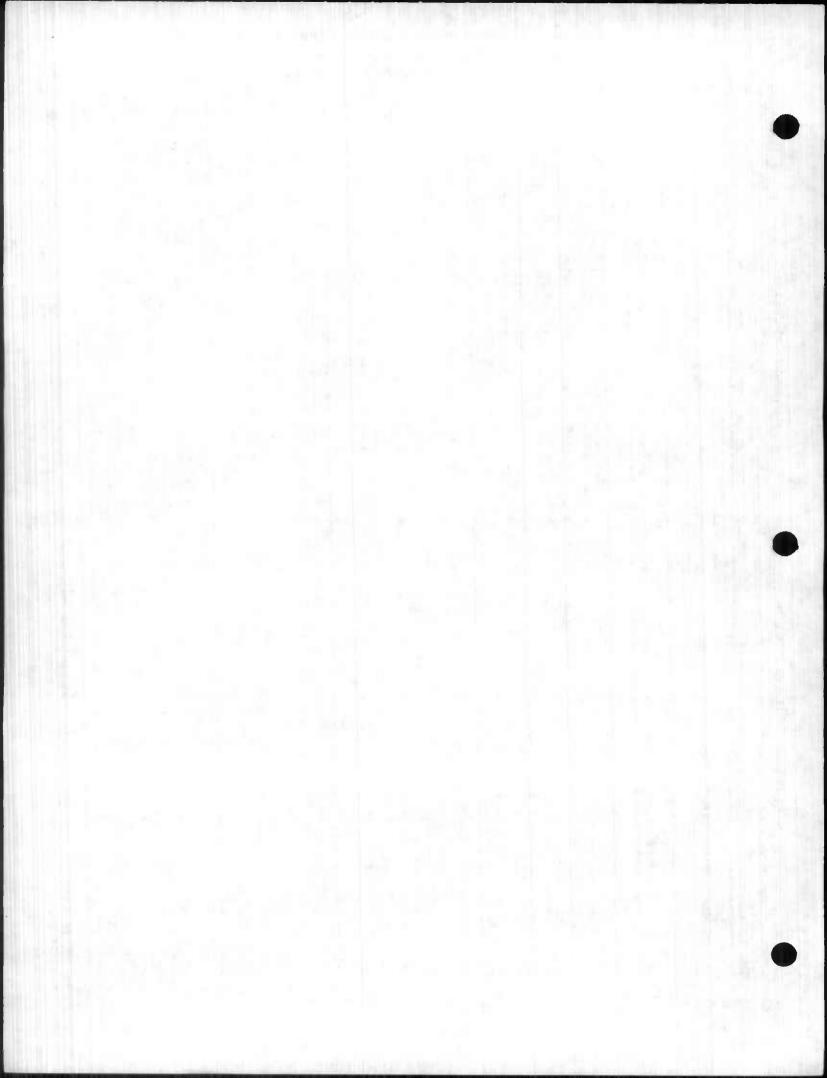


State of Maryland / Department of Health and Mental Hygiene 00 29058

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middla, Last) SEPTEMBER Day 11, 2000 IRMA J. SMITH 18:56 PM 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death PRINCE GEORGES HOSPITAL PRINCE GEORGES CHEVERLY Birthplaca (State or Foreign Country) If Undar 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) Feb 29, 1936 7. Age (In yrs. last birthday) 1□ M 20 F Months Davs Hours Min Yrs. 64 NC 238-48-3394 Usual Residence of Deceden 10h County 10c. City, Town or Location 10d. Inside City Limits Prince Georges Hyattsville 1 ☐ Yas 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6050 Sargent Rd 5104 20782 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 Ď No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. Black, White, etc. 1 Nevar Marriad 2 ☐ Marriad 1 ☐ Yes 2 No Specify: Specify. black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highast grede completed) 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) social worker social services 18 Mother's Name (First Middle Maiden Sumema) 17. Father's Name (First, Middla, Last) Saddie Whitner Ulysses Acker 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Milton McIver/nephew 16706 Wardlow Rd Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □ Othar (Spacify) 21. Signature of Funeral Service Licansee Joseph Bo Van Sant Licansee Joseph Bo Van Sant 22. Name and Addrass of Facility State Anatomy Board 655 W. Baltimore Street 21201 KM Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Immediate Cause (Final disease or condition resulting in death) Cerebral anoxia mucus nua Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown and purinal 24b. Were autopsy findings available prior to completion of cause of death? torugual frequence 24a. Was an autopsy End stage rend difense 1 Yas 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical

**Physician** 

/Medical

Examiner

10a State

Director

Funeral

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Completed

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**Funeral** 

Director

the Marylend

permit Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mentel Hygiene.
Important: If item 27 is marked other than "natural", or flams 23s or 25s-f ahow with fourly or other treumatic event, the Wed on Examine Institute to notifie 1 and 1 and

Baltimore, Maryland 21215-0020

lew requires that the death certificate be empty B attending physician for use es the burnet the signed by t d be detect peeu The

is certificate hes t director, page 2 s To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, to

Division of Vital Records, P.O. Box 68760,

Physician/Medical by Completed Be 10 Certification:

edicai

Examiner

25. Was case refarred to medical examiner?

1 ☐ Yes 2 ☐ No

27. Manner of Death Neturel 5 Pending investigation 2 Accident

3 Suicide 4 \( \text{Homicide} \)

6 Could not be determined

Hospitel: 1 Impatient 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Dey Yeer)

Injury

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28b. Time of

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifiar

29a. Certifier

29c. Licansa number

29d. Data signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

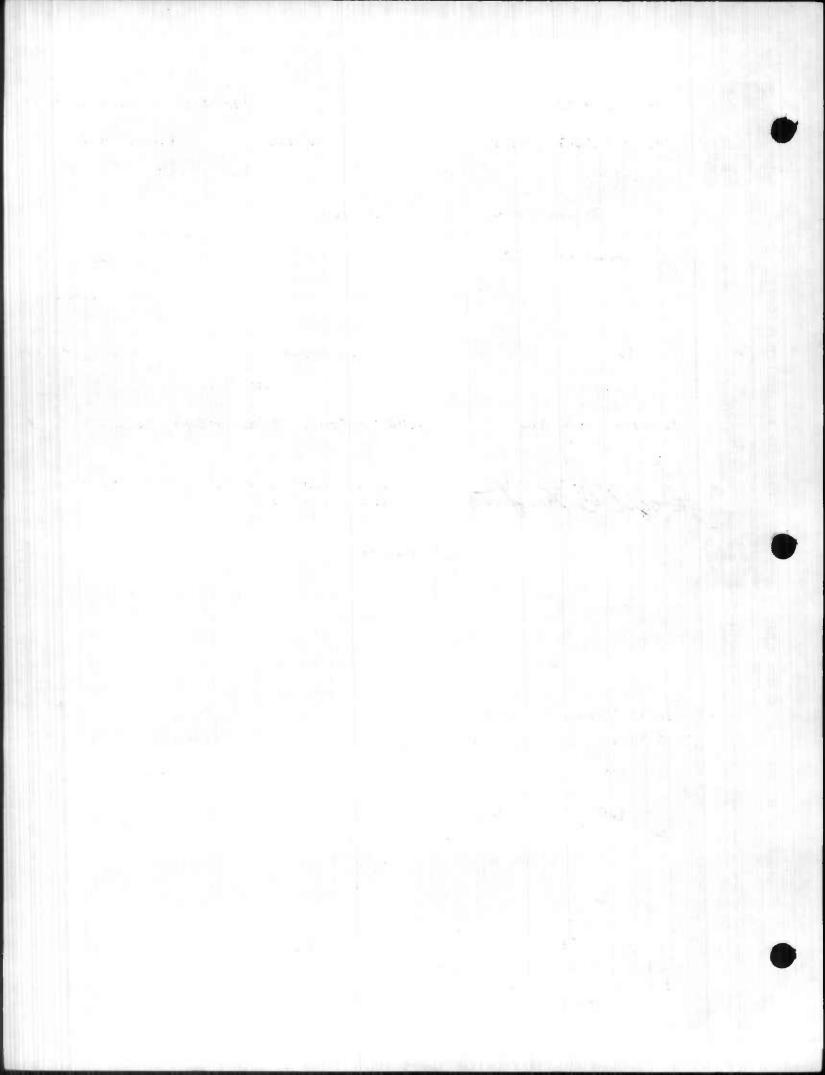
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2000 32. Registrar's Signature

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Registrar **DHMH 16 Rev 6/95** 

State



Physician	
/Medical	
Examiner	

SANDY

3. Tima of Death 16:29

10d. Inside City Limits

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Approximate Interval Batween Onset and Death

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YEARS

**Funeral** Director Harrie 23s or 28a-f show

Directo

Funeral

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Examiner must be notified at "netural", or Mental merked

72 hours after Pages 1 and 2 should be

Maryland 21215-0020 partition of the party of the party of the party of other any lejuny or other any lejuny or other and and any lejung or other and and any lejung or other and and any lejung or other any leju Baltimore, **Physician** /Medical Examiner The law requires that the death certificate be executed attending physician and lor use as the burial-tran Box 68760, 88 P.0. Division of Vital Records, certificate has or Attending Physician; this After death. Director: after within 24 hours aft To the Funeral Di completely filled in

Physician/Medical

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Certification:

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State Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month L. SEPTEMBER 10 2000 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death BALTIMORE UNIVERSITY OF MARYLAND MEDICAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Dey, 1) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Months Days Hours 10 M DOK 220-86-3261 31 03 Usual Residence of Decedent 10c. City, Town or Location 10a. State NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 U.S.A. 2341 Eutaw Place Apt 3F1 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 XNo If Yes, Give Year or Dates: XNever Married 2 Married 1 Yes 2 No Specify: Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Rite Aide Store 12th grade Security 18. Mother's Name (First, Middle, Maidan Surname) 17. Father's Name (First, Middle, Last) Geraldine Harris John C. Sanders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) John C. Sanders-Father 7401 Inwood Road, Catonsville Md 20b. Place of Disposition (Nema of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 9/15/2000 Randallstown, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice Licensee 22. Name and Address of Facility March F/H West Tan 4300 Wabash Ave, Baltimore Md Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or hear failure. List only one ceuse on each line. Immediate Cause (Final disease or condition rasulting in death) PANCREATITIS ACUTE Due to (or as a consequence of): HIV Due to (or as a consequence of) Due to (or as a consequence of)

Sequentially list conditions, if any, leading to immediate ceusa. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last

Part II. Other algriffcant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 KNo

24b. Were autopsy findings available prior to completion of cause of death?

26. Placa of Death (Check only one)

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1 Yes 20 No

2 Accident

3 Sulcide

29a. Certifier

4 Homicide

27. Manner of Death 1 Natural

5 Pending Investigation 6 Could not be

28e. Place of Injury - At homa, farm, street, factory, office building, alc. (Specify)

1) Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 Yes 2 No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stata)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number P13356 29d. Date signed (Month, Dey, Year)

SEPTEMBER 10 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

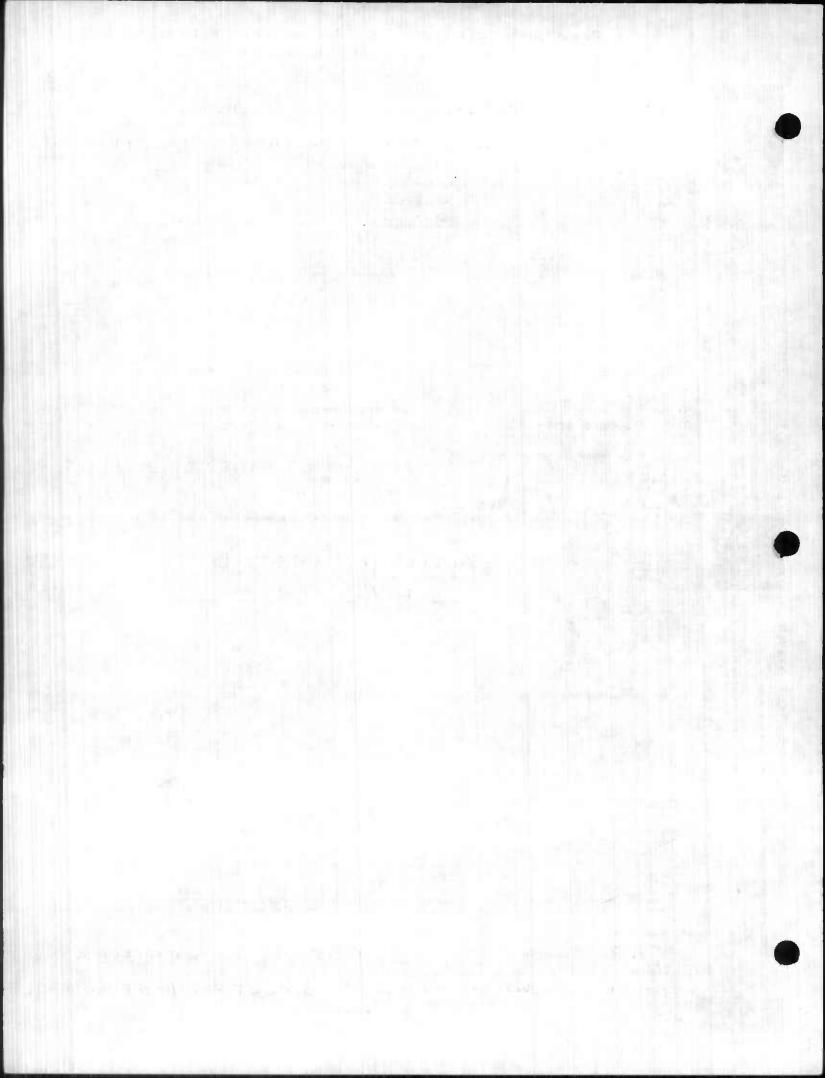
Hospital:

HEATHER ANDREWS 22 SOUTH GREENE STREET BALTIMORE MD 21201

SEP I 4 2000

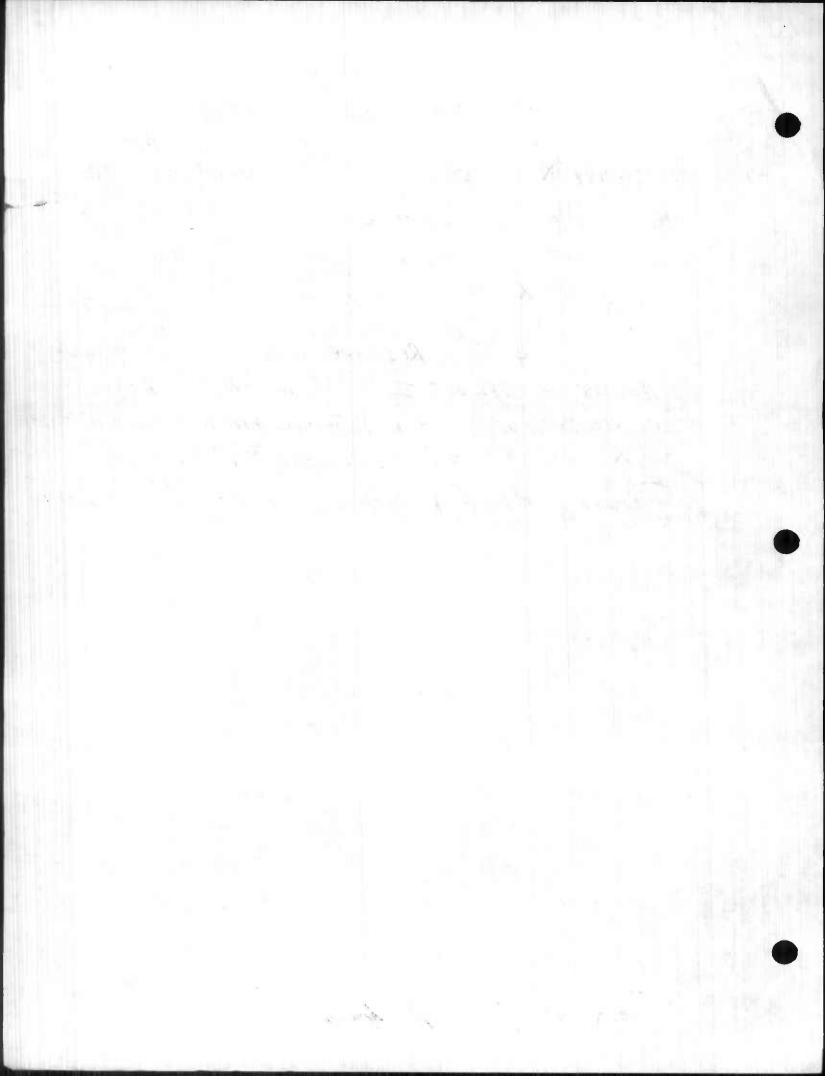
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32. Registrar's Signature



## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Physician		H. SPLI	ENT -TT		Month	Day	Yeer 2000 2116 PM
	/Medical	4e Facility Name (If not institution, give		EDI III	4b. City, Town, or			
	Examiner	30 N. PATTERSON			BALTIMOR		12	lA
	Funeral	5. Social Security Number 6. S	ex 7. Age (In yrs. I	est birthday) If Under 1 Y	ear If Under 24 Hrs.	8. Dete of Birt	h Vacel	9. Birthplace (State or Foreign
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	be filed within tall Hygiene. d other than event, the Be Comp	17. Father's Neme (First, Middle, Last)	4	KESTORE		ne (First, Middle,		BUSINESS
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ds,	8 69 Q					24a. Wes	en eutopsy	24b. Were autopsy findings
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Re	The lew requir sate has been s page 2 should Completed					160	res 2□No	197es 2□ No
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	oral Dist	CO- Codfine 4D Codfile	found at reside			riveride,	Baltimore,	Maryland
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by Medical Certiff	29s. Cartifier 1 Certifying Ph (Check only one) Medicat Exam	ysician: To the best of my know iner: On the besia of examinet and manner steted.	ion and/or investigation, in	my opinion, deeth occi	urred et the time,	dete and pleca, a	and due to the cause(s)
	vithin or the comple	29b. Signeture end title of certifier	1	29c. Li	cense number		29d. Dete signed	1 (Month, Day, Year)
	->-0	4	1/2/		OCME		SEPTEMBE	R 9, 2000
		30. Neme and address of person who	completed cause of death (Item	23a) (Type, Print)				
		David R		111 Penn Str	et, Baltin	nore, Ma	ryland 2	1201
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	Registrar	SEP 14 200	U /	IN DECEM	Total Control of the			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month Marie H. Sauter 0 00 4a. Facility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Mariner Health-Catonsville Catonsville Baltimore 5. Social Security Number 7. Age (In yrs. lest birthdey) 94 Yrs. if Undar 1 Year if Under 24 Hrs. Hours Min. 6. Sex 8. Dete of Birth (Month, Dev. Year) Birthplace (Stete or Foreign Country) 10 M 20 F Months Deys 212-30-8862 11-19-1905 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Catonsville 1 ☐ Yes 🎾 No 10e. Street end Numbar 10f. Zlp Code 10a. Citizen of What Country? 112 Fairfield Drive 21228 USA 12. Wes Decedant Evar in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Datas: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorcad Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) William F. Heinicken Margaret Heglar 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 23102 Coral Berry Way, California, Maryland 20619 Charles Sauter- son 20b. Piace of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete N☐ Buriel 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donellon 5 ☐ Other (Specify) Lorraine Park Cemetery 09-14-2000 Baltimore, Maryland 22. Name and Address of Facility Witzke Funeral Homes, Inc. of Funerel Service Licens 1630 Edmondson Avenue, Catonsville, Maryland21228 Enter the disease, or compile flores at caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, or heart feilure. List only one cause on each line. immediate Ceuse (Finel disease or condition resulting in deeth) Consistive Heart Frifan 440 Due to (or as a consequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? Atual Fibrilloon 1 Yes 2 HNT 3 Probably 4 Unknown Chron o bondow Pulmmy Disse 24b. Were eutopsy findings evallable prior to completion of cause of deeth? 24a. Wes en autopsy performed? Ross / Kilm. lla pun 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospitel: 1 Inpaliant 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 5 Pending Investigation 1 Aneturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homleide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29a. Certifier (Check only

be executed 68760. Box ( P.O. The lew requires that Records, of Vital Physician: Division or Attending Hospitai **Physician** 

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**Examiner** 

**Funeral** 

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permit. Page Department of Important: If any Injury or once.

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Registrar **DHMH 16 Rev 6/95** 

31. Date filed (Month, Dev. Year) State 1 4 2000

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29b. Signeture and title of cartifier



30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

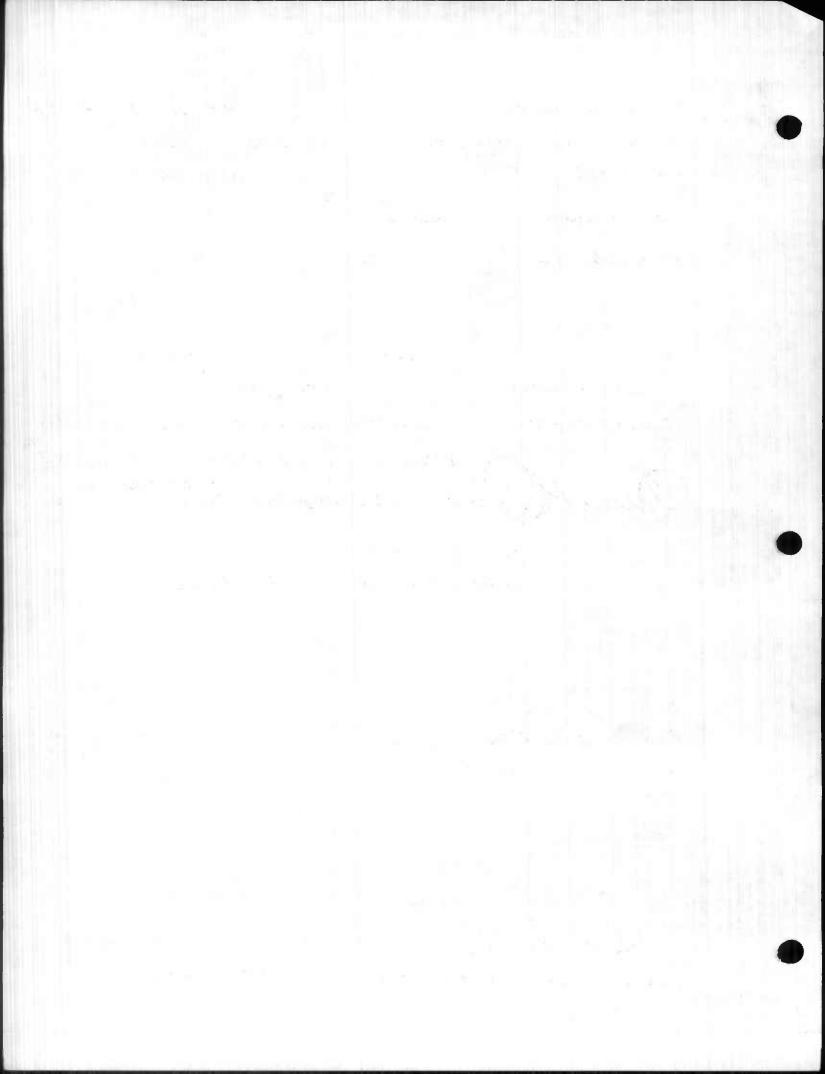
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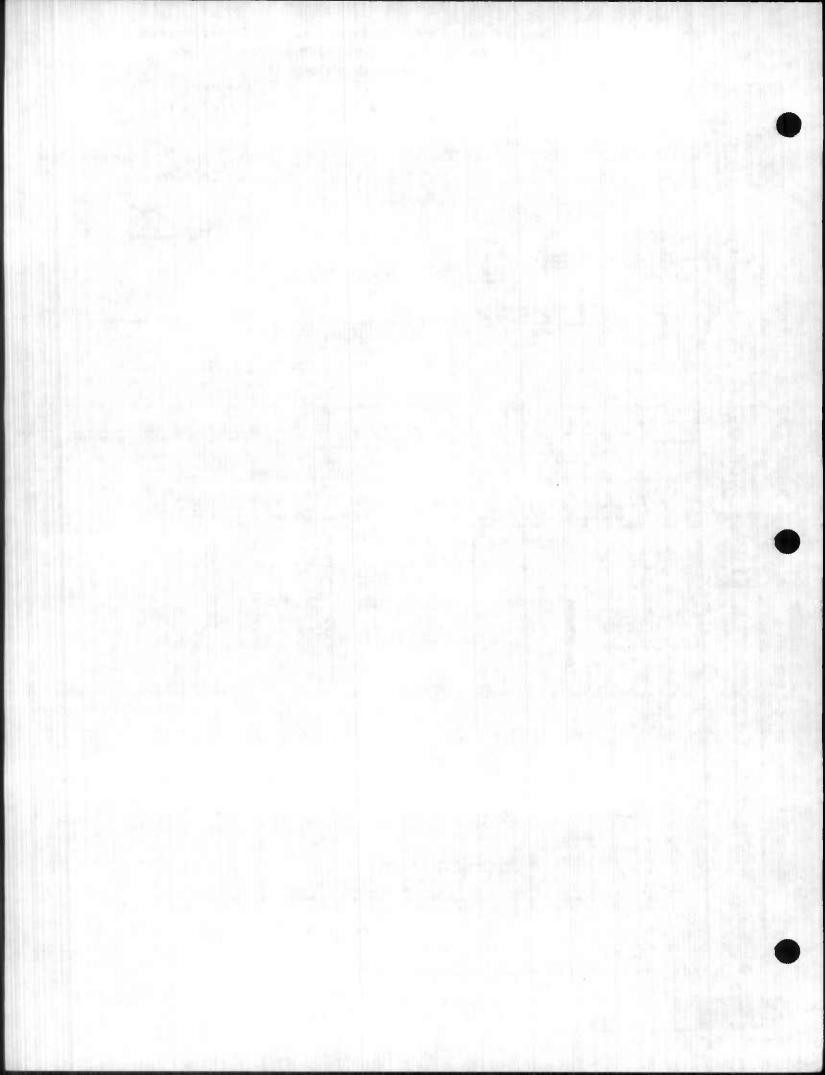


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iner	4e. Fecility Ne	ne (If not institution, g	give street and number,	)			4b. City, Town, or	Location of Dec	th 4c. Co	unty of Death	
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to	MD	n/a		Bal	timor	e					1 ☑ Yes 2 ☐ I
re	10e. Street an	d Number				10f. Zip Code			10g. Citizer	of What Cour	ntry?
0	226	. Robinson	n Street			2122	4		USA		
<b>Funeral Director</b>	11. Meritel Ste	tus	12. Was Decedent	Ever in U.S.	13. Wes	s Decedent of I	Hispanic Origin? (5	Specify Yes or N	0- 14.	Race - Americ	can Indian,
FU		Merried 2 Merried	Armed Forces		If Ye	es, specify Cub	en, Mexican, Puer	to Rican, etc.)		Bleck, White,	
by		ed 4 Divorced	If Yes, Give Yeer or Detes:		1 🗆	Yes 2⊠ No	Specify:		Sp	ecify: W	nite
		15. Decedent's			6a Deceden	it's Usuel Occup	netion		16h Kind	of Business/In	duetry
et		Specify only highest g	grade completed)		(Give kin	d of work done NOT use retire	during most of wa	rking	TOD. KING	Or Dusiriess/III	dustry
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Be							18. Mother's Ne Rôse C		e, Melden Su	meme)	
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	Joseph	Scelsi		2	226 S.	Robins	on St.,	Baltimo	re, Ma	ryland	21224
	20e. Method o		-	camel	of Disposition	on (Neme of lony or other ple	ce)	Deta	20c. Locat	ion - City or To	own, Stete
		2 ☐ Cremetion 3 ion 5 ☐ Other (Spec	Removal from Stete	Oakla		.,		9/13/00	Baltin	more, M	daryland
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	7//	www/L.	7		263	South Co	nkling Str	eet, Balt	imore,	Maryland	21224
	shock, o	heart feilure. List on	ornolications that cause my one cause on each I	ine.	o not enter t	ine mode or dyl	ng, such as cardle	c or raspiratory	arrast,	1	Approximata Interval Between Onset and Death
Examiner	Sequentielly I	st conditions, to immediate Underlying	<b>b</b>	Due to (or es						1	
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dica	causa. Enter Ceuse (Disees that initiated a resulting in de	vents									
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w	Ceuse (Disease that initiated a resulting in de	vents eth) Last	ds contributing to death b	out not resulting	g in the unde	orlying cause give	ven in Pert I.	23b. Dic	I tobacco use	s contribute to	o the cause of de
	Ceuse (Disease that initiated a resulting in de	vents eth) Last	Λ		1		ven in Pert I.		I tobacco use		
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by Physician/Me	Ceuse (Disease that initiated a resulting in de	vents eth) Last	Λ		1		ven in Part I.	1 [ 24a. We	Yss 2 121	76 3 □ Pro	bably 4 Unki
by Physician/Me	Ceuse (Disease that initiated a resulting in de	vents eth) Last	Λ		1		ven in Pert I.	1 [ 24a. We	Yes 2 12-1	3 □ Pro	bably 4 Unknown under autopsy finding allable prior to impletion of cause
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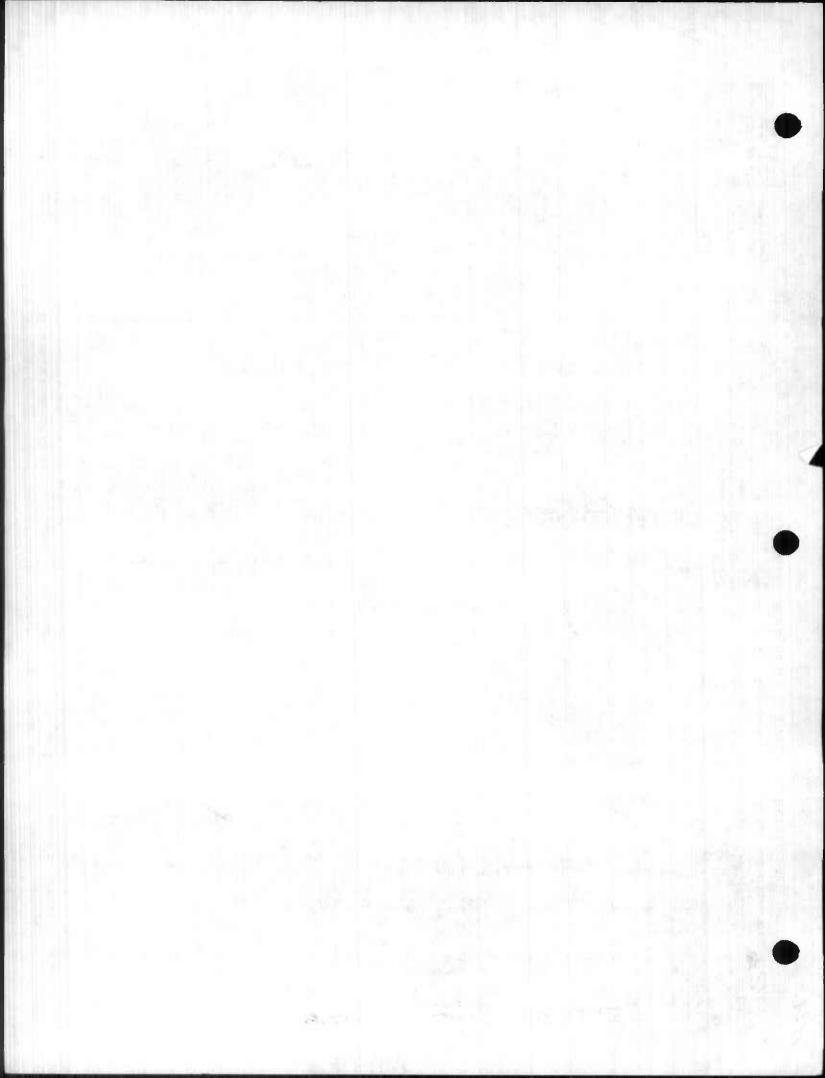
State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death	Reg. No.	29065
	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Physician /Medical	MICHAEL	SEMILIO	SEPTEMBER 10, 200	
Examiner	4a Facility Nama (If not institution, give street and number)	medical .	, or Location of Death 4c. County of Dea	ath
	Johns Hopkins Bayview		finure n/a	Ab 1 (Cana - 5
Funeral Director	5. Social Security Number  6. Sex  7. Age (In yrs. I)  9. O  158 M 2 F  9. O  158 M 2 F			nthplace (State or Foreign country) Italy
A show fad at tor	10a. Stata 10b. County 10c. City MD Baltimore	, Town or Location	Baltimore	10d. Inside City Limits 1 ☐ Yas 2 ☒ No
with the Marylar he or 28e-f show Libe notified at i Director	10e. Street end Number 7023 E. Baltimore Street	101. Zip Code 2 1 2 2 4	10g. Citizen of What C	Country?
urs after death af, or items 2 Examiner mus by Funers	11. Marital Status  12. Was Decedent Ever in U, Armed Forces?  1 Never Merried 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U, Armed Forces?  1 Yes 2 No It Yes, Give Year or Dates:		17 (Specify Yes or No- ruanto Rican, etc.)  14. Race - Am Black, Wh	ite, atc.
Ta ho	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of	16b. Kind of Business	s/Industry
ygiene.  ver than 'natur it, the Medical.  Completed	Elementery/Secondary (0-12) Cotlege (1-4or 5+) 7 t h	Tailor	Clothi	ng/
d other	17. Fathar's Nama (First, Middle, Last)	18. Mother's	Name (First, Middle, Maiden Surname)	
Menti miles To	Anthony Semilio		ia Marciano	
and is made	19e. Informant's Name/Relationship (Type, Print) daughte	19b. Mailing Address (Street and Number of	or Rural Route Number, City or Town, State,	Zip Code)
and and the state of the state	Rosemarie Locklear	7023 E. Baltimore St		
Pages 1	1 W Burial 2 U Cramation 3 L Hemoval Iron State	lace of Disposition (Name of emetery, crematory or other place)  dens of FAITH	9/14/00 Baltimore	, Maryland
Depart Import any Inj ance	21. Signature of Funeral Service Licensee  Maria 11 Zann	22. Name and Address of Facility 263 South Conkling St	Joseph N. Zannino, .t., Baltimore, Maryland	Jr. Funeral Ho 21224
	23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one ceuse on each line.	n. Do not enter the mode of dying, such as ca	rdiac or respiretory arrest,	Approximete Interval Between
hysician				Onset and Death
/Medical   xaminer	Immediate Cause (Final disaesa or condition resulting in deeth)	G CANCER		4 MONTH
STATE OF		r es a consequence of):		
n and ial-transit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	r as a consequence of):		
g physicia as the bur Aedical	Cause (Disease or Injury that Initiated events resulting in death) Last  Due to (or	as a consequence of):		
signed by the attendir d be detached for use d by Physician/N	d	ulting In the underlying cause given in Part I.	23b. Did tobacco uss contribu	te to the cause of death?
00			1 Yes 2 No 3	Probably 4 Unknown
s been 2 shoul			24a. Was an autopsy performed?	available prior to completion of ceuse of death?
ate hes t page 2 s			1 ☐ Yes 2 No	1 ☐ Yes 2 No
is certificate director, pag	25. Wes casa reterred to medical examiner?		t Death (Check only one)	
H sign	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐		ing Home 5 ☐ Residence 8 ☐ Other (Sp	pecity)
After th funeral	27. Manner of Deeth 28a. Date of Injury (Month, Day Year)	28b. Time of Injury at Work?	28d. Describe how injury occurred	
To the Hospital or Attending P within 24 hours after death. To the Euroral Director: Aftert completely filled in by the funer Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At hobiding, etc. (Specify	M 1 ☐ Yes 2 ☐ No ome, farm, street, factory, office /)	281. Location (Street and Number or City or Town, State)	Rural Route Number,
within 24 hours after death within 24 hours after death To the Funeral Director: completely filled in by the Medical Certifical	29e. Certifier  (Check only one)  Medical Examiner: On the basis of my known aximinat one)  and manner stated	wledge, death occurred at the time, date and p ion and/or investigation, in my opinion, death	place, and due to the cause(s) and manner occurred at the time, date and place, and d	as stated. ue to the cause(s)
Mec Mec	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Data signed (Mo	nth, Day, Year)
- 3 - 8	Nenneth C. Bilduck, 1		11/1	FR 10,2000
3	30. Name and address of person who completed cause of death from KENNETH C. BILCHICK 494()	(Type Print) AVE . PA	stemore Macylawa	21724
State Registrar	31. Data filed (Month, Day, Year)  32. Registrar's Signal	ture & Sparts		



State of Maryland / Department of Health and Mental Hygiene

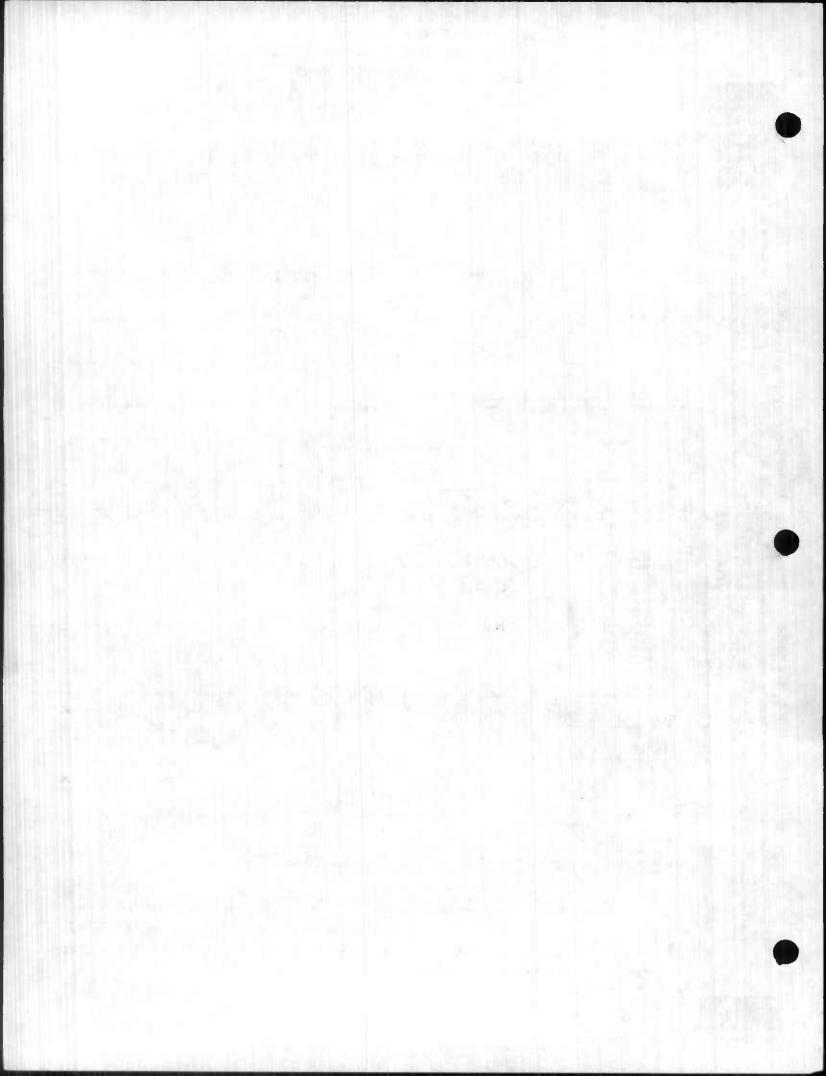
						Ce	rtificat			F	leg. No.	0 2	9066
Physic	ian		ne (First, Middle, Las	st)				2"		2. Date of Dea Month	Day	Yeer	3. Time of Death
/Medi		EV				S	IEGEL				BER 11,		12:47PM
Exami	ner		(If not institution, give 310 LAURI		er)				4b. City, Town, or I BALTIM		4c. County		LTIMORE
Funeral Director		5. Social Security I 213-10-	5203	ex □M 2 <b>X</b> F	Age (In yrs. 85	last birthdey Yrs.	Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Da) NOV • 30,		9. Birthple Count	ace (State or Foreign ny) MD
yand Mana		10a. State	10b. County		10c. Cit	y, Town or L	ocation					10	d. Inside City Limits
Maryla a-f show lifed at	tor	MD	BALTIMO	RE		BALTI	MORE						1 ☐ Yas 2 💢 No
th with the Man 23s or 25s-f sh ust be notified.	al Director	10e. Street and Nu 3310 L	AURI ROAD				10f. Zip	Code	21244		U.S.A		ry?
har dea	by Funeral		ried 2 Married 4 Divorced	12. Was Decedor Armed Force 1  Yes 2 If Yes, Give Year or Date	es? XNo	,S. 13.	Was Dece If Yes, spe 1 Yes		Hispanic Origin? (S en, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race Biac Specify	e - America k, Whita, e	
21215-0020 d within 72 hours at giene. r than "natural", or the Medical Exam	Completed	Elementary/Sec	_ ' ' '	lucation de completed) Collège (1-4	or 5+)	(Give	DO NOT u	rk done	during most of wor	king	16b. Kind of Bu		ustry
d 2 d 2		17. Father's Name	(First, Middle, Last)			HOMEM	AKER		18. Mother's Nan	ne (First, Middle,	OWN H		
Maryland 42 should be lile in and Mental Hyp 7 is marked othe traumatic event.	o Be	HARRY				MIZANSKY MARY						-	ANK
ary show	-		lame/Relationship (7	Type, Print)				(Street	end Number or Ru	ral Route Numbe	r, City or Town,		
- 53N h		ROBERT	SIEGEL /	SON		4409	CHAP	ELDA	LE ROAD	- RANDAL	LSTOWN,	MD 2	1133
Baltimore  John Pages 1:  Johannest of He  mportant: if hen  ny injury or othe  most.			position  Cremation 3   5 Other (Specify		ate	Place of Disponentery, cree	matory or c	ther ple	CENVEREIN MER	Date 9/13/00	20c. Location -		
Balti permit. Departm imports any inju		21. Signature of F	uneral Service Licen	see		2	22. Name ar	d Addre	ess of Facility PERSTOWN 1	SOL LEV	INSON &	BROS	., INC.
C8760, Wedicale be executed the private by physician and the burnal-fransit as the burnal-fransit	fedical Examiner	Immediate Cause disease or condition resulting in death)  Sequentially list or if any, leading to licause. Enter Und Cause (Disease or that initiated event resulting in death)	onditions, mmediate erlying r injury		Due to (c	Coras a conse	equence of):	en (	diou pac	ular	Diea		Interval Between Onset and Death
deeth cert deeth cert de attendim ed for use	an			d								i	
O. E. dee	Physician/N	Part Ii. Other signi	ficant conditions co	ontributing to deat	h but not res	ulting in the	underlying o	ause gi	ven in Part I.	23b. Did t	obacco usa cor	ntributs to	the cause of death?
IS, P.O. res that the de signed by the a	by Phy									101	/88 2 No	3 Prob	ebly 4 ₩ Unknown
aw requi	Completed									24e. Wes perfo	en autopsy med?	ava	re autopsy findings illable prior to npletion of cause leath?
- ga	Con									101	es 21 No	1 🗆	Yes 2□ No
Of Vital   Physicien: The this certificate rai director, pag	Be	25. Was case refe axaminer?		Hospital				0		ath (Check only o	ne)		
ai di	5	1 Yes 22 27. Manner of Dea	3 140	Hospital: 1 ☐ Inp	eatient 2	ER/Outpatie		JA		lome 5 Resid	ence 6 Oth		)
nding ath.	Certification:	1 Natural 2 Accident 3 Suicide	5 Panding investigation	(Month,	Day Year)	Injury	М		ry at rk? ] Yes 2 □ No				
DIVIS To the Hospital or Atte within 24 hours after de within 24 hours after de completely filled in by it	Certif	4  Homicide	determined	building	, etc. (Specil	y) 				City or Tou			
e Hospital n 24 hours e Funeral pletely filled	edical	29a. Certifier (Check only one)	1 ☐ Certifying Phy 2 ☐ Medical Exam		s of examina								
To the To the comple	M	29b. Signature and	title of certifier		7		29	c. Licen:	se number		29d. Date signer	(Month, L	Day, Year)
		109	enold	800	n	M	0	0	1587	2 5	epter	- by	12 2000
V)		30. Nameyand add	ress of person who d	completed cause	of death (Item	1 23a) (Type	(Print)	R	erdir	dean	Md	211	36
Sta Regist		31. Date filed (Mor	SEP 1 4 7	32. Reg	istrar's Signa	ature	4	100	K				



State of Maryland / Department of Health and Mental Hygiene

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Amended	Item#26 perPHYG	787 9/	14/2000 E	J	Cei	rtifica	te of	f Death		Re	g. No.		bas of	00,
	1. Decedent's Name (First,	Middle, La	st)			1			2.	Date of Deatl Month	Day	Year	3. Tim	ne of Death
Physician (Madical	Tony						Ne	lonis	S	eptemb	20- 1 :	2000	10:	05 Pm
/Medical Examiner	4a Facility Name (If not ins	litution, giv	e street and nun	nber)				4b. City, Town			4c. County	of Death		
Adminici	JUHNS HOPKI	US BA	YVIEW	MEDICA	IL CEN	TER		BALTI	MOR	E				
eral ctor	5. Social Security Number 212-58-2897	6. 5		-	lest birthday) Yrs.		Day:		Min.	Dale of Birth (Month, Dey, ept 8,	Year) 1952	9. Birthp Coun unk	itry)	ate or Foreign
.01	Usual Residence of Decede	ent								tepe o,	1772	ulik		
Funeral Director	10a. Stafa 10b. C	ounty		10c. Ci	ty, Town or Lo	ocation	-					1	Od. Insk	da City Limits
ō	MD	N	/A		Baltim	ore							1)(1)	Yas 2□No
Director	10e. Street and Number		,		Dureri	-	p Code		_00	10	Og. Citizen of V	What Coun	itry?	
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era	336 S. Le	nigh	12. Was Dece	dent Ever in I	15 13 1	Was Dece	adent of	21224	n? (Specifi	v Yes or No-	14 Rac	USA e · Ameno	an India	in.
by Funeral	1 Never Married 2 □		Armed For	rces? 2  No e		If Yes, spo		Hispanic Origin ban, Mexican, I o Specify:	Puarto Ric	an, etc.)		ck, White,		
		edenf's Ed			16a. Deced	dent's Lie	ial Occi	upation			16b. Kind of Bi	usiness/Inc	dustry	
Completed	(Specify only	highest gra	ide completed)		(Give	kind of w	ork don	e during most o	f working		OD. MING OF DI	43111033FTT	200119	
E	Elementery/Secondery (0	-12)	College (1	_			200 70111	04)						
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Be	17. Fathar's Name (First, M	ddie, Last)						18. Mothers	s Name (F	irst, Middle, N	reiden Sumen	10)		
0	unk	7						unl	k					
	19a. Informent's Name/Rel				19b. Meilir	ng Addres	s (Stre	et end Number	or Rural R	loute Number,	City or Town,	Stete, Zip	Code)	
	Johns Hopkin	s Bay	view Me	d Ctr	4940	Eas	terr	n Ave 1	Balti	more,	MD 212	224		
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremi 4 ☐ Donation 5 ☒ Ott				Place of Dispo cemetery, crer	osition (Na metory or	ame of other p	(ece)	1	Date	20c. Location -	City or To	iwn, Stal	le
1	21. Signature of Funeral Se	rvice Licer			1.0			ress of Facility			N. Balt	imore	e St	reet
	Pagl. Enter the disea shock, or haart feilura	se, or com List only	plications that cr ona cause on e	aused the dea ach line.					2120		est,	1	Approximate Interval Between Onsat and Deat	
	fmmediate Cause (Final disease or condition resulting in death)		eA	PDS									we	eks
5					or as a consec								weeks	
F			b. 0.51	piratio	on pue	enmo	onic	(				i	me	लरड
Examin	Sequentially list conditions if any, leeding to immadial cause. Enter Underlying Cause (Disease or Injury		EN		or as a consecutive CE LI			SENE				1	ye	ars
Medical	that initiated events resulting in death) Last	1	d		or as a conseq									
Physician/M			0.									1		
SIC	Part II. Other significant co	nditiona c	ontributing to de	ath but not res	sulting in the u	inderlying	cause	given in Part I.		23b. Did to	bacco usa co	ntributa to	o the ca	use of death
4	TOLO									1 U Y	a 2 No	3 Pro	bably	4 M Unknow
by	DIC								-					
Completed	UGIB	Ya.								24a. Was a perform		ev	ailable p	opsy findings prior to n of cause
E										1 □ Ye	s 2 No	1[	Yes	2FL No
	25. Was case referred to m	edical		-				OC Disease	d Dooth //			1		
Be	examiner?	edical	Hospitel:					Whor:		Check only on				
10	1 ☐ Yes 2 ☑ No		1)(1)		ER/Outpatier	-	NA	4LI Nurs	-		nce 6 Oth		у)	
Certification:	2 Accident	ending ivastigation	n	of Injury h, Dey Year)	28b. Time of finjury	М	1	jury et /ork? □ Yes 2 □ No	0		w injury occur			
Certifi		etermined	28e. Place buildir	of Injury - At h ng, etc. <i>(Speci</i>	oome, ferm, str fy)	reet, facto	ry, offic	0	281	City or Town	reet end Numi n, Stete)	oer or Hun	II Houte	Number,
Medical												use(s)		
2	29b. Signature and title of o	ertifier				25	9c. Lice	nse number			9d. Date signe			
	Day 7				m 02c) (T	Priot	2	1004		S	eptem	ber	1, 2	000
	Amy Freedu	an	4940	Easter	rn Av	enu (	2 /	Baltimo	re,	ub				
tate	31. Date filed (Month, Day,			egistrar's Sign	ature 6		Can	A						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Veer **Physician** 13:35 0 0 00 /Medical 4b City Town or Location of Death 4e Facility Nama (If not institution, give street end number) 4c. County of Death Examiner 4940 Eastern Ave. N/A Lospita Day Ures 5. Social Security Number If Under 24 Hrs. 7. Aga (In vrs. last birthdev) **Funeral** Days Months Hours 1□ M 2□ F 79 219-28-5475 Yrs Director Sept. 4,1921 Maryland Usual Rasidance of Decedent with the Meryland 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ahon the Medical Examiner must be notified at 1 ☐ Yas 2 ☑ No Director Dundalk Baltimore Maryland 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? United States 21222 7423 School Lane Funeral death Herne : 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 14. Race - American Indian, Bieck, White, atc. 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yas, Giva 1 Nevar Merried 2 Married 8 Maryland 21215-0020 1 ☐ Yes 2X No Specify: White Completed by 3€ Widowed 4 Divorced Yaer or Detes: "neturel", 16a. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then then Elementary/Secondery (0-12) College (1-4or 5+) Distillery Lineworker 8 Years other 17. Fethar's Nama (First, Middle, Last) 18. Mothar's Nema (First, Middle, Maiden Sumame) and Mental h Peges 1 and 2 ahould be Minnie I. Weir Charles Campbell 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) nt of Haaith a: If Item 27 is 7423 School Lane Dundalk, Maryland 21222 Mrs. Wilma Rutter (Daughter) Baltimore, 20b. Place of Disposition (Nama of camatery, cramatory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Removal from State permit. Pege Department of Important: If eny Injury or pace. Oak Lawn Cemetery 9/15/2000 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Signature of Funeral Service Licensee 22. Nema and Addrass of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. 21222 23a. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset end Death **Physician** /Medical Immediata Causa (Final englom disease or condition resulting in death) 000 Examiner Due to (or es a consequence of) Physician/Medical Examiner wio The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): 68760 attending physician Dua to (or as a consequence of): usa as the Box P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? datached the 1 Yes 2 No 3 Probably 4 Unknown signed by þ of Vital Records, should be 24a. Was en autopsy 24b. Wara autopsy findings Be Completed peen available prior to complation of ceusa of death? this cartificate has paga 2 1 Yas 2 No 1 Yes 2 3 No Physician: Director: After this cartific d in by the funeral director, 25. Was case referred to medical axaminar? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Medical Certification: To 28c. Injury at Work? 27. Mannar of Beath 28b. Tima of 28d. Describe how injury occurred Division Attending 5 Panding invastigation 1 (INatural death. 1 Yas 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 6 Could not be determined 3 Suicida 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) filled in by after a 4 Homicide To the Hospital
within 24 hours a
To the Funeral C
completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the ceusa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and titia of cartifier 29d. Date signed (Month, Day, Year) 29c. Licansa number 30. Nama and addrass of person who complet d cause of death (Item 23a) (Type, Print) Pules

**DHMH 16 Rev 6/95** 

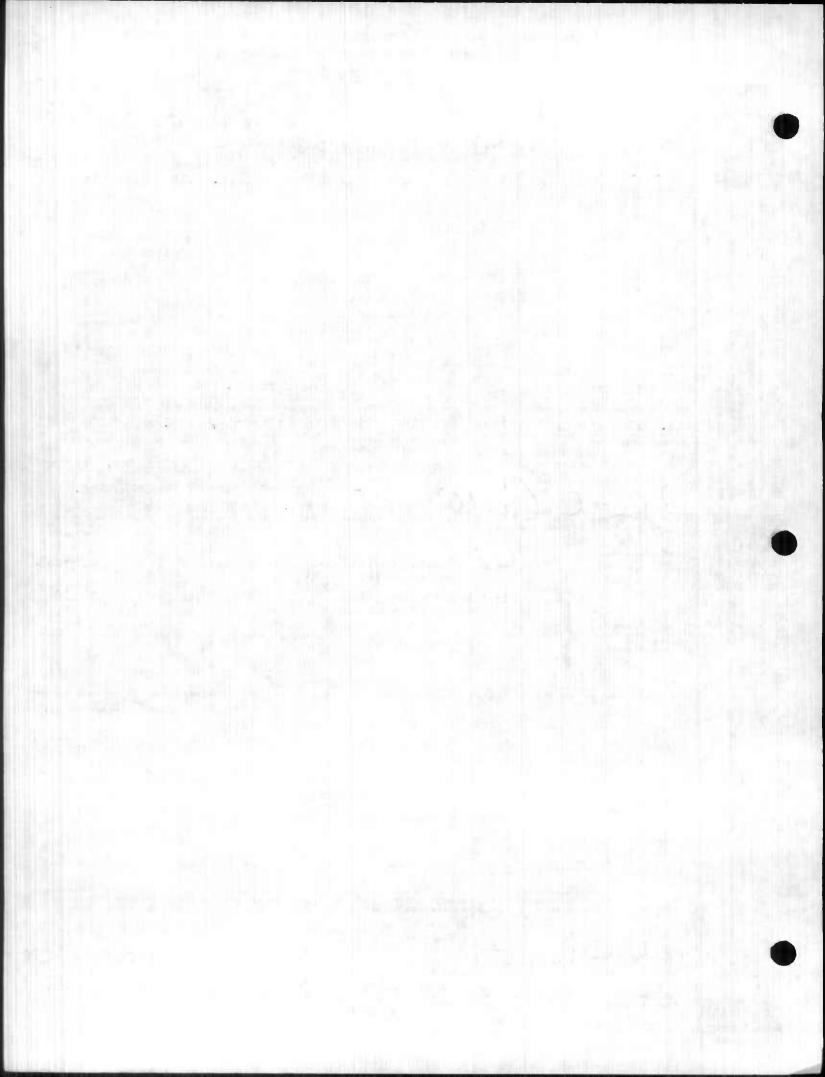
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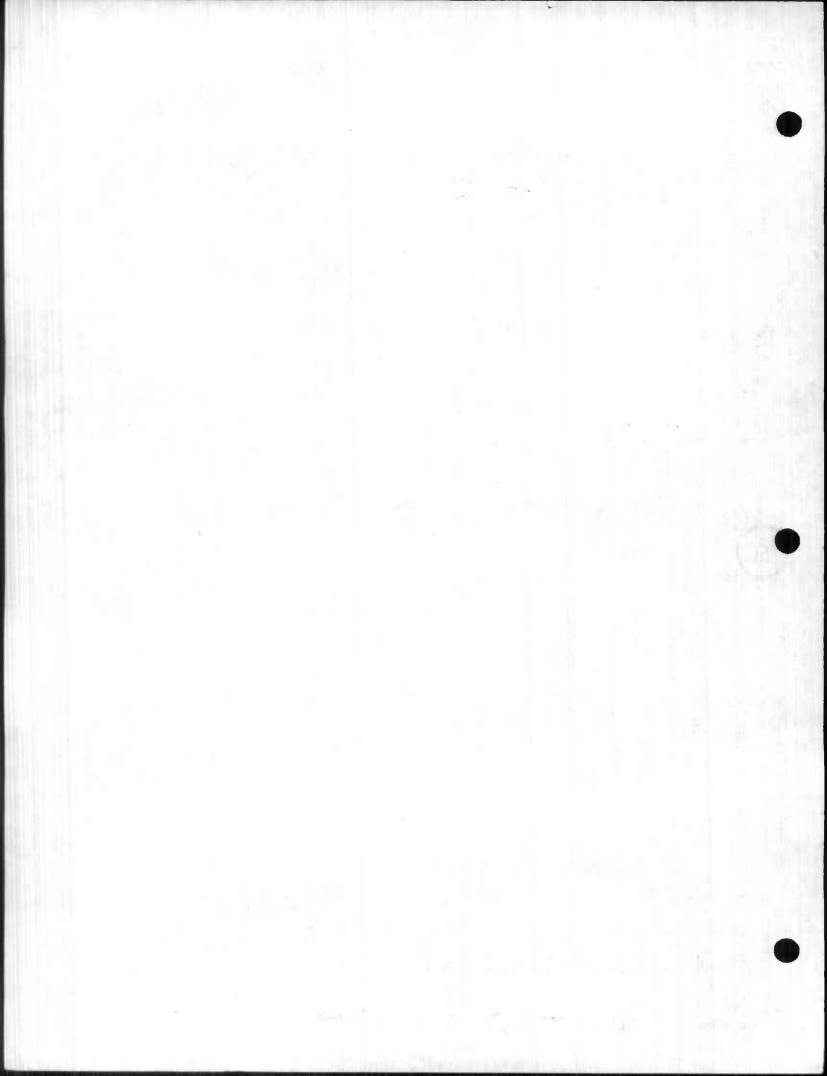
32. Registrar's Signature



B.F	K.S /IN WHIT	ľE			land .	Department of I Department of I IGertificate o	Health and	lental Hyg	jene WR	n 29069
	Physician /Medical		1. Decedent's Neme (First, Middle, Last  ALU(N	,		ITE	i Dealli	2. Date of Dea Month SEPT.	eg. No. th Dey 1, 2000	Yaer 0710 AM
	Examiner		4a Facility Name (If not institution, give SINAI HOSPITAL  5. Social Security Number 6. Şe		vrs. last	birthdey) If Under 1 Ye	4b. City, Town, or Lo  BALTIMO  ar   If Under 24 Hrs.	RE	4c. County	of Death  // A  9. Birthplace (State or Foreign
	Funeral Director	0	243-52-1578 P Usuel Residence of Decedent	M 20 F	50	Yrs. Months Den		April 8	Year) 1950	maryland
death with the Maryland	23a or 28a-f show Let be noviled at		10a. State 10b. County  Md ,	1/A 10	c. City, 1	Poul Apt 10f. Zip Code	timore		Og. Citizen of W	10d. Inside City Limits  10 Yes 2 □ No  Thet Country?
_ 6	P. P. P.		2615W Belv  11. Marital Stetus  1 Never Married 2 Married	12. Wes Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give	in U,S.	. 13 2	1215 1 Hispenic Origin? (Spuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		S. A.  s. American Indien, k, Whita, atc.  Black
1215-0020	ygiene. Ar than "natural", o A, the Heales Ex-		3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest gred Elementery/Secondary (0-12)	Yeer or Detes:	-	6a, Decedent's Usuel Occ	supation ne during most of work ired)	ing rKer	16b. Kind of Bu	
ind 21	T TO S		17. Fether's Name (First, Middle, Last)	10/4	,	Machen 1991	18. Mother's Nem	e (First, Middle,	Maiden Sumem	0)
Maryland		1	19a. Informant's Neme/Reletionship (7)			19b. Meiling Address (Stre		al Route Numbe	r. City or Town,	State, Zip Code)
- 5	Health em 27 other tr	-	Deborah White 20a. Melhod of Disposition	- WIFE	Ob. Plec	2615 W. Belu e of Disposition (Name of		APT 1B		, md. 21215 City or Town, State
Baltimore	artment of ortant: If it Injury or o		1 Buriel 2 Cremetion 3 F 4 Donation 5 Other (Specify)	Removel from State	77 U	etery, cremetory or other p	cem	16/2000	Lans	
Bal	Department important:		23. Pert1. Enter the disease, or compl shock, or heer feilure. List only o	Livenin	deeth.	4517 PG	rehigh	WiS T. ( task) or respiretory err	Baet	Approximate Intervel Between Onset and Deeth
601	hys⊪ian ∕∄ed cal xam.ner		Immediate Cause (Final disease or condition resulting in deeth)	CAR	DIA	C ARRHYTHM	IIA			0.130( 0.13 )
	, i			CAR	to (or es	c HYPERTRO	PHY			
ox 68760, certificate be execute	physicials the burnedical	3000	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last			e consequenca of):				
P.O. Bo	ed by the detached		Pert II. Other eignificant conditions con CIRRHOSIS OF T		ot resultin	ng in the underlying cause	given in Pert I.		obacco uee cor /es 2 PNo	ntribute to the cause of death?
Vital Records,	2 shoul	a named in						24a. Wes a	an autopsy med?	24b. Wera autopsy findings evailable prior to completion of cause of death?
Ral B	s certificate he director, page		25. Wes case referred to medical				26. Piece of Dee	1 Check only o		1 ☐ Yes 2 □ No
of Vita	als certification of director		exeminer?	lospitel:	2 X ER	/Outpatient 3□ DOA	Other:	ome 5 Resid		er (Specify)
Vision of	五百		27. Menner of Death  1 Neturel 5 Pending 2 Accident investigation	28e. Date of Injury (Month, Day Ye	-	b. Time of 28c. In	njury at Vork? Yes 2 No	28d. Describe h		
5 8	rs after death.  al Director: After t led in by the funers  Certification:		3 Suicide 6 Could not be determined	28e. Piece of Injury - building, etc. (S	At home	, ferm, street, fectory, office	CA	28f. Location (S City or Tow		er or Rural Route Number,
Ne Hospital	E4 hourstell fill the fill the fill fill fill fill fill fill fill fil					dge, deeth occurred et the and/or investigation, in m				
Total	To the comple		29b. Signature and title of certifier    Lewis Jan	uky			o.C.M.E			d (Month, Day, Year) 1 , 2000
	State		30. Name and address of person who co Denns J. Chu 31. Date filed (Month, Dey, Year)	ompleted cause of deeth fe w 32. Registrer's	111	Penn Stree	t, Baltimo	re, Mary	land 21	201

Registrar

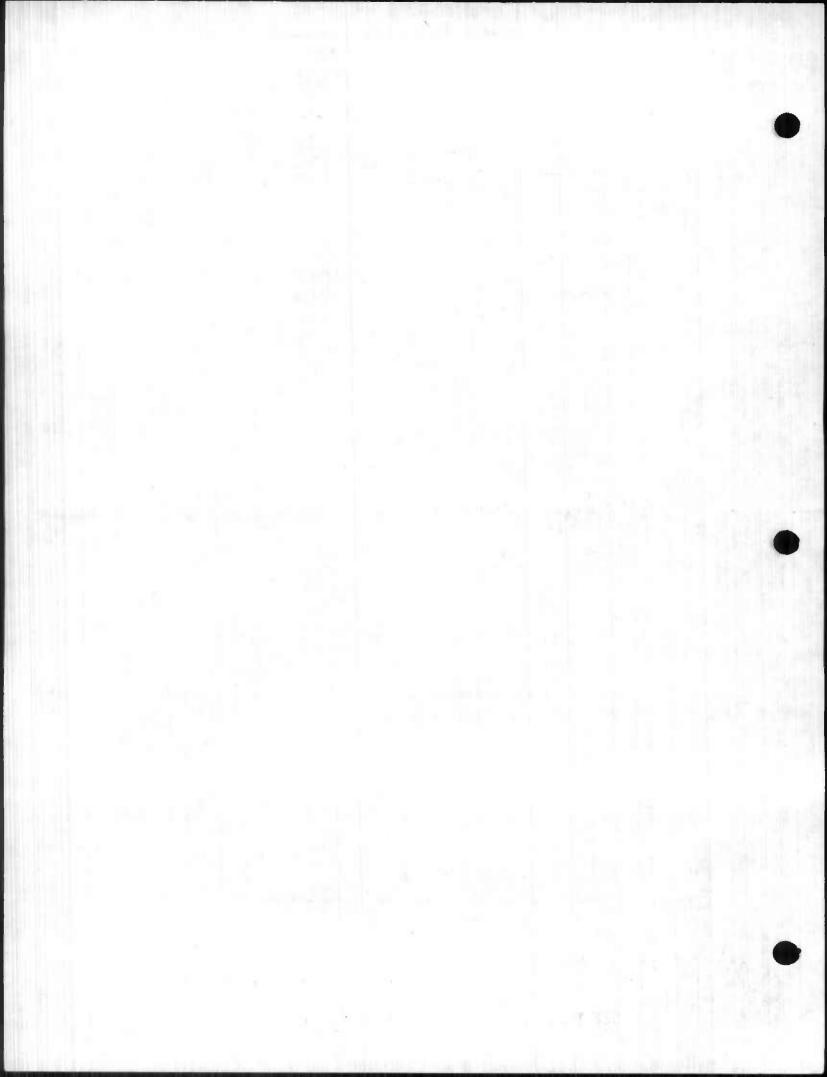
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State of Maryland / Department of Health and Mental Hygiene

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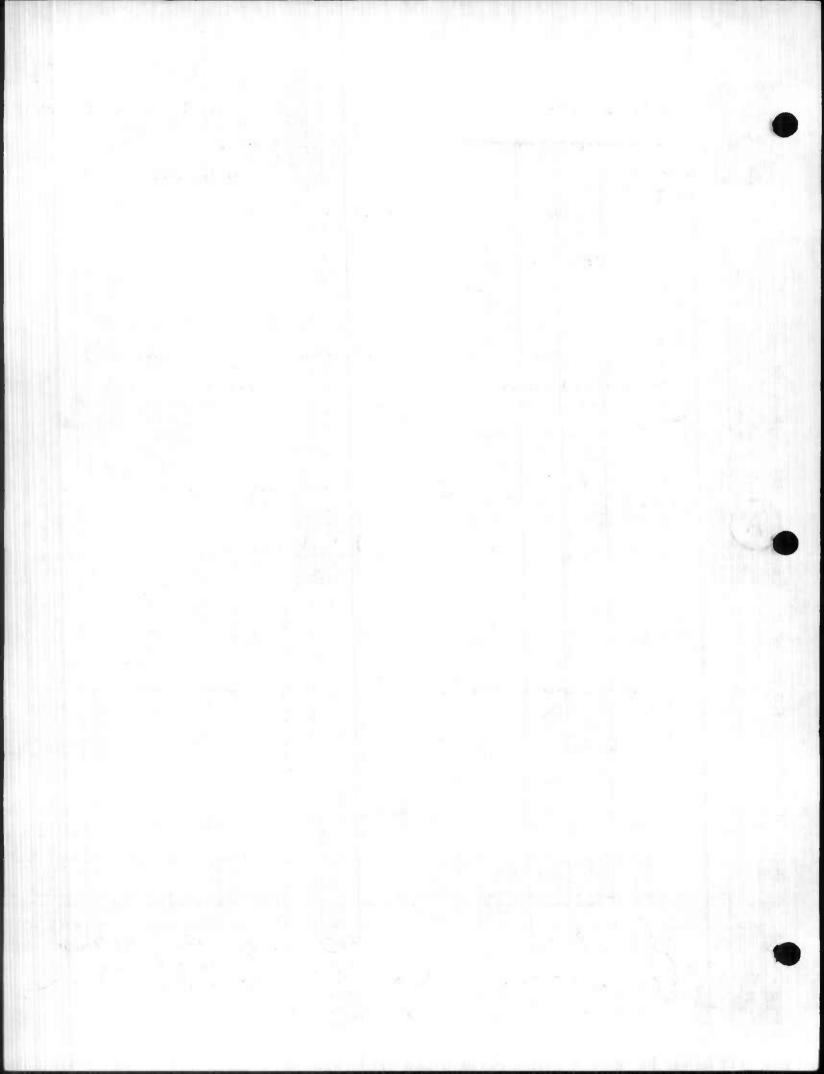
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	Decedent's Name (First, Middle, Last)								2. Date of D Month		Year	3. Time of Deat	
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medicai kaminer	4a Facility Name (If not institution,	rive street and nu						wn, or Lo	cation of Dea		nty of Death		
	1622 East 32nd	Street					Bal	timo	re	1	N/A		
eral	5. Social Security Number 6	Sex	7. Age (In yrs.	last birthday		r 1 Year	If Under	24 Hrs.	8. Date of Bi (Month, D	irth Voos	9. Birth	place (State or Fore	
ctor	215-24-2679	1□M 2□F	71	Yrs.	Months	Deys	Hours	Min.	01-03		Cot	MD	
	Usual Residence of Decedent												
4	10a. State 10b. County		10c. C	ity, Town or L	ocation							10d. Inside City Lim	
io io	MD NA	1	Ba	altimo	ore						T.V	XXYes 2□	
9 2	10e. Street and Number	M. Den.			7	p Code				10g. Citizen o	of What Cou	intry?	
al Director	1622 32nd. Street 21218									US	SA		
direct author noticed	11, Mental Status		edent Ever in U						ecity Yes or N		14. Race - American Indian,		
Fu	X⊠Never Married 2 Married	1 ▼ Yes	Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates:						Rican, etc.)	8	lack, White	, etc.	
by	3 Widowed 4 Divorced	If Yes, Gi			1□ Yes	2□ No	Specify:			Spe	Bla	rck	
Completed	15. Decedent's	Education		16a. Dece	edent's Usu	al Occup	ation		100	16b. Kind of			
pie	(Specify only highest (		de completed)		DO NOT	ork done o use retired	du <i>ring</i> mos d)	t of work	ing				
E	Elementary/Secondary (0-12)	College (	1-40r 5+)	Tec	chnic	cian				Monte	aomer	y Wards	
	17. Father's Name (First, Middle, La							18. Mother's Name (First, Middle,				7	
o Be	North		Marro			A	D.,	h	Ch				
To	19a. Informant's Name/Relationship	(Tyne Print)	Warre		ing Addres	s (Street	Ru and Numb	or or Bur		nee City or Toy	vn State 7	ip Code) 2121	
	Rochelle	Garlan	a									Marvland	
	20a. Method of Disposition	Gallan		Place of Disp			iew.	Avei	Date Da	20c. Locatio			
	1⊈ Burial 2 ☐ Cremation 3		State	cemetery, cre	ematory or	other plac				127			
	4 Donetion 5 Other (Spe	cify)	Ga	rrisc	on Fo	res	t VA	Cen	09-	15-200	00 OV	rings Mi	
any injury	21. Signeture of Funerel Service Lic	ensee		2	22. Name a	nd Addres	ss of Facili	Ba	altimo	re, Ma	arvla	and 2120	
2 2	M lal.		04.01	1 6	M.C.	Mar	ch F			North			
100	23a. Part1. Enter the disease, or or shock, or heart failure. List on	mplications that	caused the dea								1 1100	Approximate Interval Between	
	Immediate Cause (Final disease or condition resulting in death)	Hyper a.		e Arte			tic C	ardi	ovascu.	lar Dis	ease	Chiset end Deat	
i i	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Hyper	Due to (		equence of)	): :	tic C	ardi	ovascu	lar Dis	ease	Onset end Dean	
Medical Examiner	disease or condition resulting in death)	a. Hyper a  b  c  d	Due to (	or as a conse	equence of)	): :	tic C	ardi	ovascu	lar Dis	ease	Onset end Death	
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or use as the bunar-transmiller fan/Medical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	a b c d contributing to d	Due to (  Due to (  Due to (e	or as a conse or as a conse or as a conse	equence of) equence of) underlying	): :			23b. Dic		contributa	to the cause of de	
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pieted by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant conditions	a b c d contributing to d	Due to (  Due to (  Due to (e	or as a conse or as a conse or as a conse	equence of) equence of) underlying	): :			23b. Dic 1 C 24a. Wa per Insy	diobacco usa  ] Yea 2  No s an autopsy formed?  Dection	contributa o 3 pr	10 the cause of de obably 4 Unk Vere autopsy findir vailable prior to completion of cause of death?	
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ector, page 2 should be detached for use as the burial-transit  Be Completed by Physician/Medical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other eignificant conditions  Renal Failure	a. b. c. d.	Due to (  Due to (  Due to (  eath but not recently a comment of the comment of t	or as a conse or as a conse or as a conse sulting in the d	equence of) quence of) underlying	cause giv	en in Part	e of Deat	23b. Did 1 24a. Wa per Inst	diobacco usa ]Yes 2 No s an autopsy formed? Dection ]Yes 2 Moo	contributa o 3 Pr	10 the cause of de obably 4. Unk Vere autopsy findir vailable prior to ompletion of cause of death?	
To Be Completed by Physician/Medical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant conditions  Renal Failure  25. Was case referred to medical examiner?  1½ Yes 2□ No  27. Menner of Death  1∑Natural 5□ Pending	a b c d contributing to do of Undet	Due to (  Due to (  Due to (  eath but not recemined	or as a conse or as a conse or as a conse	equence of) underlying logy	cause giv	26. Place	e of Deat	23b. Did 1 = 24a. Wa per Inst 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 =	diobacco usa ]Yes 2 No s an autopsy formed? Dection ]Yes 2 Moo	contributa o 3 Pr  24b. v	10 the cause of de obably 4. Unk Vere autopsy findir vailable prior to ompletion of cause of death?	
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Amend	led	Item#4a perPHYG787 9		yland	/ Department of I		ental Hygie		00 2	9071		
	-1	1. Decedent's Name (First, Middle, L					2. Date of Death 3. Time of Death					
Physicia	_	Tolel samo	loam !				Month Day Year					
/Medica Examine		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town, or Lo	cation of Death	40. Count	of Death	102 P IV		
Examine	er	LORIEN FRANKFORD		0		20110	0.00	4g. Count				
Funeral		5. Social Security Number 6.	Sex 7. Age (	In vrs. las	t birthday) If Under 1 Year	If Unider 24 Hrs.	8. Date of Birth		9 Righniage	(State or Foreign		
Director		220-03-4365 Usual Residence of Decedent	400 14 000 0	90	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye Feb 12,		Country)	(State or Foreign		
th with the Maryland 23a or 28a-f show	ctor	10a. State 10b. County	I/A 1	Oc. City,	Town or Location Baltimor	e				nside City Limits		
or 28	Sire	10e. Street and Number			10f. Zip Code		10g.	Citizen of	What Country?			
23a	<u>a</u>	2302 E. Oliver	Street			21212						
or items	by Funeral Director	11. Marital Status  12. Was Decedent Ever Armed Forces?  12. Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever Armed Forces?  1 Yes, Give Year or Dates:			13. Was Decedent of If Yes, specify Cub  1 ☐ Yes 2 ☑ No	oan, Mexican, Puerto F	cify Yes or No- Rican, etc.)	USAmerican li ck, White, etc. y: blac				
natural',		15. Decedent's E			16a. Decedent's Usual Occu	pation	168	o. Kind of B	usiness/Industr	y		
- 4	Completed	(Specify only highest grade completed)  Elementery/Secondery (0-12)  College (1-4or 5+)			16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire							
Hygiene. ther than		17. Father's Name (First, Middle, Las	U		labore		(Fine Minde Mar)	un				
Mentel arked o	To Be	Christopher C. W.	•				ther's Name <i>(First, Middle, Mald</i> en <i>Sum</i> Cora Madison			iame)		
th and Mentel Hyg	ř	19a. Informant's Name/Relationship			19b. Meiling Address (Street			ity or Town	, State, Zip Coo	(e)		
er tr		unk			unk							
rtment of Healt rtant: If item 27 njury or other		20e. Method of Disposition  1 Buriai 2 Cremation 3 [ 4 Donation 5 Other (Speci	Removal from State	20b. Plec cam	e of Disposition (Neme of etery, crematory or other pla	ce)	Date 200	. Location	- City or Town,	State		
hysic an injury sones.		21. Signature of Euneral Service Lice 100 A 100 S 200 A 200	1 Wille	-	Baltimore Do not enter the mode of dyi	atomy Boar MD 2120 ng, such as cardiac or	O1 respiretory arrest,		Apr	Street eroximete eval Between eet and Death		
Medical Examiner		Immediate Cause (Final disease or condition resulting in deeth)	a. Is che	e to (or e	C H Fan	r li	sease	2	M	lay		
ansit	Examiner	Sequentially list conditions	b		s a consequence of):							
	dical Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	C		a consequenca of):							
	Physician/Medi	resulting In death) Last	d	5 to (or as	a consequence ory.							
the ette	SICIA	Part II. Other significant conditions	contributing to death but n	ot resultin	ng in the underlying cause gi	ven in Part I.	23b. Did tobac	co use co	ntribute to the	cause of death?		
	by Phy	Cerebron	asule o	l'a	ease		1 🗆 Yes	2□ No	3 Probably	4 🗓 Unknow		
	Completed	Lichetos	huel	e'.	fry		24a. Was an a periormed	utopsy  ?	availeb	utopsy findings e prior to tion of cause 1?		
ate has b	0	De ou	101				1 ☐ Yes	20 NO	1 ☐ Ye	2 1 No		
£ 6	0	25. Was case referred to	/			26. Piece of Death						
	ToB	examiner?	Hospitai: 1 ☐ Inpatient	2∏FP	/Outpatient 3□ DOA Oth	ner:	e 5 Residence	6 1704	er (Specific)			
		27. Menner of Seeth	28a. Dete of Injury	28	b. Time of 28c. Inju		Bd. Describe how in					
or deeth.	OILE	1 Naturai 5 Pending 2 Accident investigation	(Month, Day Ye	ear)		rk?  Yes 2 □ No						
is after deeth.  In Director: After the in by the funer.	eume	3 Sulcide 6 Could not be determined	e con Diana attains		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Funer Funer tely fill	_	29a. Certifier 1 Certifying Pr (Check only one) 2 Medical Exam	ysician: To the best of m niner: On the basis of exa and manner stated	amination	dge, deeth occurred at the tir and/or investigation, in my c	me, date and placa, as opinion, death occurre	nd due to the cause d at the time, date	e(s) and ma and place,	anner as stated and due to the	cause(s)		
within 2 To the		29b. Signature and title of certifier	< ,		29c. Licens	se number	29d.	Date signe	d (Month, Day,			
		yeur and	W 12	,	1/2	18355	2	ug	317	000		
17.10	1	do Name and address of person who	completed cause of death	(Item 23	ia) (Type, Print) SEA	cito V	. PA	TRI	100			

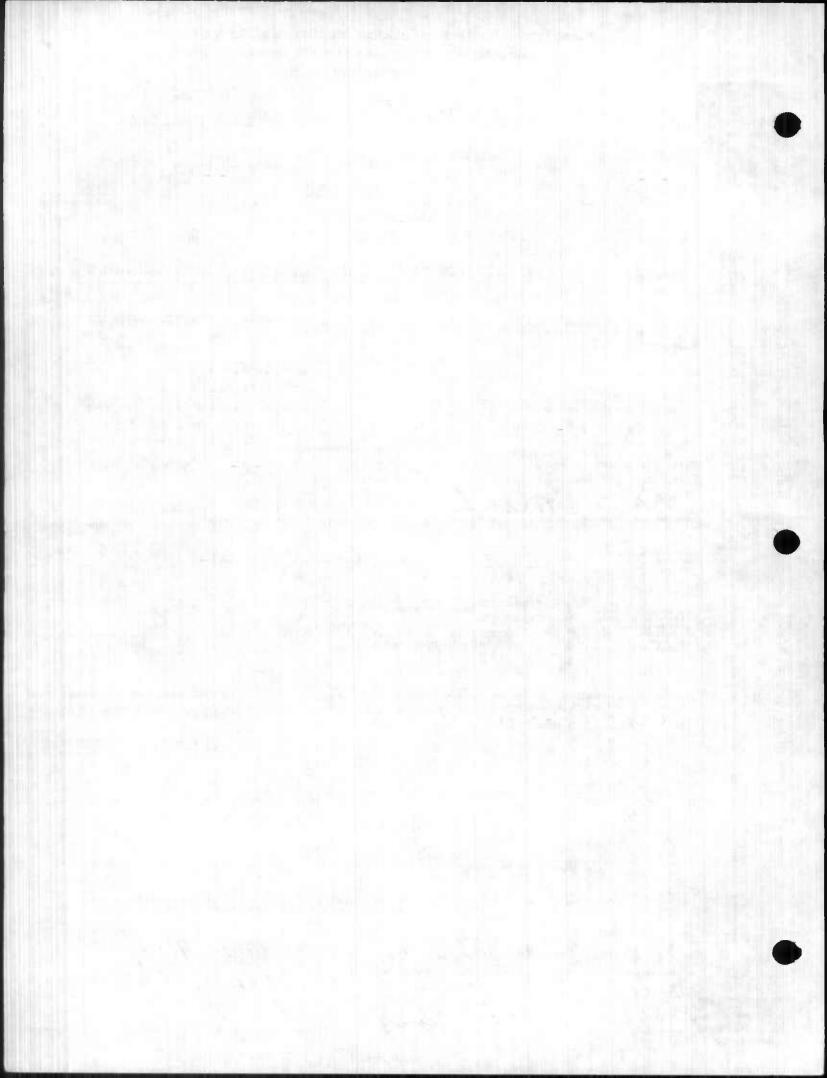
State Registrar 31. Date filed (Month, Day, Year) SEP 1 4 2000

32. Registrar's Signature



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					State of	iviaiyia		,	ificate of	f Death	Memain	Reg. No	U	0	29072	
Г	11		1. Decedent's Nam	e (First, Middle, L							2. Dete of D Month			Year	3. Time of Death	
- 3	Physici /Medic		PERC	Y L.	WAY	RREI	N,	SF	Κ.		9	7	200		9 00 p.m.	
	Examir		4e Facility Name (		iva street and num	ber)				4b. City, Town, or		- 100	c. County o	of Death		
			4222 Ivar		nue				Williamore	Baltimore			N/A			
	Funeral Director		5. Sociel Security N 219-26-72 Usual Rasidance o	235	Sex 7	Age (In yr.		rs.	Months Day			rth lay, Year -194(	3	9. Births	placa (State or Foreign ntry) V a	
	Maryland f show	or	10a. State	10b. County			altir							1	10d. Insida City Limits 1  Yes 2 □ No	
21215-0020	death with the Maryland	Funeral Director	10e. Street and Nu 4222 IV	mber Vanhoe Av	enue		10f. Zip Code 10g. Citizen of What Country?						ntry?			
	urs after al', or its	by	11. Marital Status  1 Never Marr 3 Widowed	ied 2√X Married 4 □ Divorced	Armed Ford	12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates:		13. Wes Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 Yes 2 No Specify:			pecify Yes or No- 14. Race -			, White,	Amaricen Indian, Vhite, etc. Black	
5-0	72 ho	Completed	15. Decedent's Ed (Specify only highast gra		ducetion rade completed)	fucetion			nt's Usuel Occ	rkina	16b. F	Kind of Bus	siness/In	dustry		
121	ithin	nple m	Elementary/Seco	ondary (0-12)	College (1-	4or 5+)		(Give kind of work dona during most of work life. DO NOT use retired)				C	City Home		es	
	should be filed within ad Mental Hygiene. marked other than imatic event, to a Mental Mental than the mental control to the Mental Men		11th gr 17. Father's Nema		N/A		Home	ne Improvemen		ent 18. Mother's Name (First, Midd		# # # # # # # # # # # # # # # # # # #				
and	ad be ded of eve	Be	William		0					1000	lizabet	0.000		2)		
Maryland	2 should be and Mental is marked o	2	19a. Informant's N		(Type, Print)		19b.	Malling	Addrass (Stre	et end Number or R				Stete. Zic	Code)	
M	and 2 seath ar n 27 la			Warren -						e Avenue						
re,	Head Head		20a. Mathod of Dis	position			Place of	Disposit	tion (Nema of story or other p		Data		ocation - 0			
E	Pages nent of ant: If its ary or o			☐ Cremation 3   5 ☐ Other (Spec	Ramoval from Si				matory		-14-00	Cat	onsv	ille	. Md	
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Ikem 27 is marked other than any Injury or other traumatic event, the IMPDES.		21. Signature of Fu	peral Service Lice	ensee	,/	2010	22.1	Name and Add March	ress of Facility F/H West						
	-		23a. Pert1. Enter t	he disaese, or co	nplications that cer	used the de	ath. Do n	ot antar	tha moda of d	abash Ave ying, such as cardia	c or raspiratory	errest,	re, M	ld 2	21214 Approximata	
	Physician		Shock, or hae	on fallura. List onl										1	Interval Batween Onsat and Death	
	/Medical		Immediate Cause disaase or condition	(Final	. 0	ROP	HAR	241	UGEA	L CA	UCER				2 years	
	Examiner		resulting In death)		a	Due to	(or es e c	onseque	ence of):					1		
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	icate be executed physician and s the burial-transit	Examiner	Sequentially list co	nditions, nmadiata		Dua to	(or as a c	onsequ	ance of):							
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68760,	g phys	ledicai	resulting in death)	Last		Due to	(or as a c	onseque	ance of):							
Box	eath certifi attending	2	d.													
	0 0 0	Physician/M	Part II. Other algnificant conditions contributing to death but not resulting in the undarlying ceuse given in Part I.								23b. Did tobacco use contributs to the causs of death					
P.0	that that ed by the	Phy	ESOPHAGEAL CANCER													
	res th	by			02/12		-//									
Records,	need	Completed									24a. Wa	s an auto formed?	opsy	av	lera autopsy findings vallable prior to ompletion of ceusa	
3ec	has has	mpi											M	of	deeth?	
	E and												2/No	1	☐ Yes 2☐ No	
of Vital	Physicien: this certific ral director,	Be C	axaminer? Hospital: Other:								10	ath (Check only ona)  Ioma 5 A Residence 6 □ Othar (Specity)				
of	Phys r this rel di	1: To	1 Yas 2 2		1		28b. T		3 DOA 28c. In		28d. Describe				יעי	
on	ding F th. After funer	Tè l	1 Neturel 2 Accident	5 Pending investigati	28a. Date of (Month)	, Dey Year)	1r	njury		jury at fork? □ Yes 2 □ No						
Division	Attending or death.	Hice	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office							28f. Location (Street and Number or Rural Route Number,						
ā	s effe	Certification:	4   Homicida	☐ Homicida datamined building, atc. (Specify)								City or Town, Stata)				
	To the Hospital or Attending Physicien: within 24 hours effer death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Cartifiar (Check only one)			is of examir				time, data and place opinion, death occ						
	To the To the Comp	Σ	29b. Signature and title of certifier 29d. Date/signed (Mon										(Month.	Day, Year)		
	0		Urle	nell	Joras	lie	e	114	D	0025 1	+3	4	112	12	000	
	10		30. Nema and addr	EA, F	completed cause	of death (Its	am 23a) (	Type, P	600 i	V. WOL	FEST	,	BAL	Te	MD,	
	Sta Registr		SEP 1 4 2	th, Dey, Year)	Seperal 32. Reg	gistrar's Sign	Pature	art	5						5100	



3. Time of Death 2. Date of Death Watson September 8, 2000 5:30 A.M. 4b. City, Town, or Location of Death 4c. County of Death Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min Yrs N.C 10c. City, Town or Location 10d. Inside City Limits 1 X Yas 2 □ No Baltimore 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21213 Was Decedent of Hispanic Origin? (Specify Yes or Noff Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 1 Yes 2000 Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Disabled Disabled 18. Mother's Nama (First, Middle, Maiden Surname) 10025 Robert L. Harris /Brother Mary McClain 800 West York, End Ave, New 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 10025 800 West End Ave, New York, New York 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Md 9/14/2000 Baltimore, Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March F/H West 21. Signature of Euneral Sarvice Licens MMPSM 4300 Wabash Ave, Baltimore Md 21215 Infer the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, br heart failure. List only one cause on each lina. Approximate Interval Batween Onset and Death immediate Cause (Final disease or condition resulting in daath) BLUNT FORCE HEAD INJURIES Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of) 23b. Did tobacco usa contributa to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 1 Was 2 No 2 - No Be

Physician /Medical Examiner

The law requires that the death cartificate be executed and 68760 attending physician the Box ( P.O. the 5 ate has been signed to page 2 should be dete Division of Vitai Records. this certificate has or Attending Physician: after death. Director: After third in by the funeral

Certification: To

Medical

State

yd ni bellif

To the Hospital of within 24 hours a To the Funeral D completely filled in the completely filled

25. Was cese referred to medical 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No

28b. Time of Injury found: 14 28a. Date of Injury (Month, Day 28d. Dascribe how injury occurred subject assaulted 27. Manner of Death fnjury at Work? P 1 Natural 5 Pending 9/6/00 М 1 ☐ Yes 2 Dotto investigation 2 Accident 6 Could not be 3 Suicide 281 Location (Street and Number of Rural Route Number City or Town, State) Lanvale and Wolfe Streets Baltimore, Maryland 28e. Place of Injury - Af homa, farm, streat, factory, office building, etc. (Specify) 4 Comicida street

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mannar stated. 29a. Certifier (Check only one) and manner stated.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

September 09, 2000

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

JACK M. 11745 MID 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

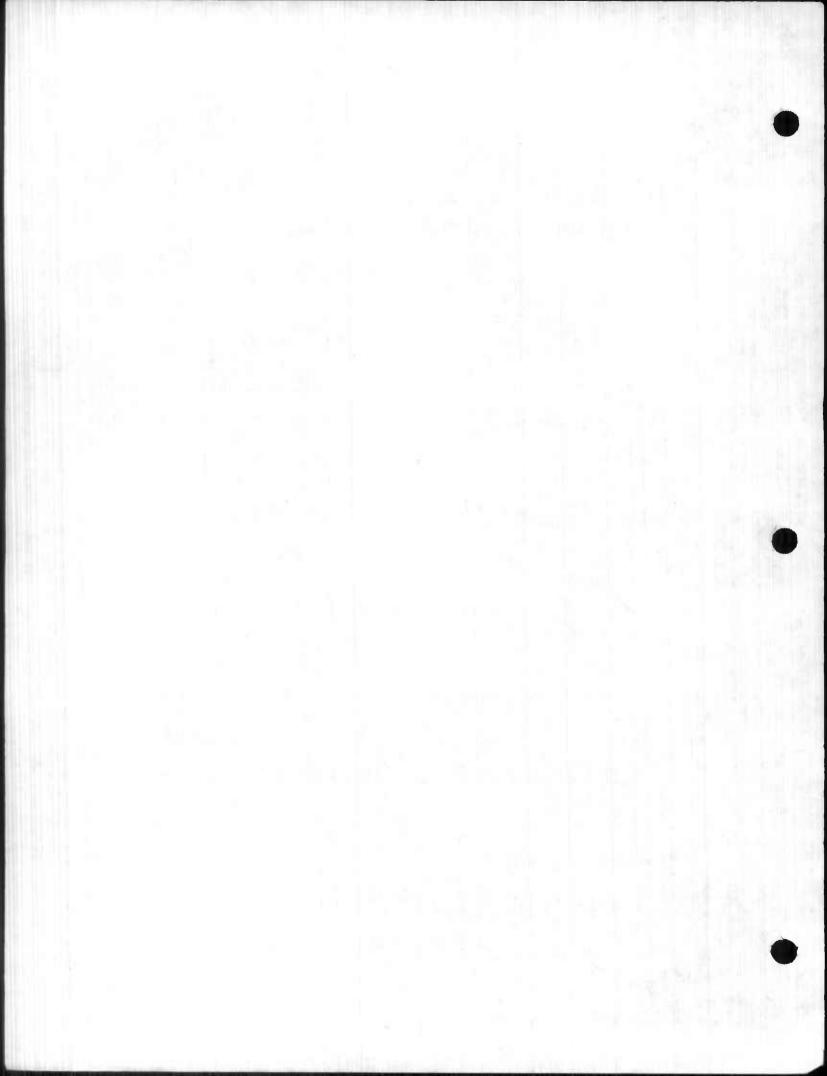
29b. Signature and title of certifier

1 4 2000

32. Registrar's Signature

books

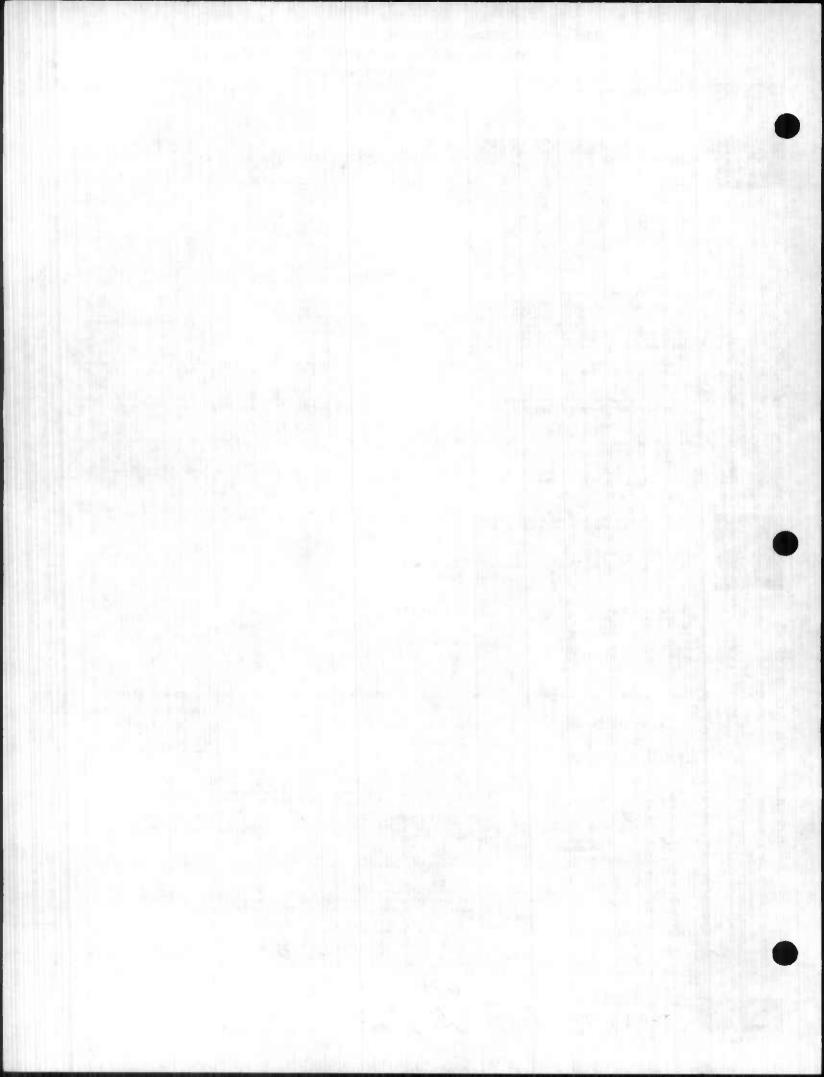
Registrar **DHMH 16 Rav 6/95** 



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** Sept.
4b. City, Town, or Location of Death Dolores 12 2000 Walker 8:30 PM /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Columbia If Under 24 Hrs. Lorien Nursing Center Howard 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□ M 20%F Days Hours Min. 214-70-9769 Yrs. 97 Director APR 17, 1903 North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iono. rthan "natural", or items 23s or 28s-f shov the Medical Examples, must be notified at 1 Yas 2 No Maryland Howard Directo Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6338 Cedar Lane 21044 USA Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, Whife, etc. 11. Marifal Status Blad within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Black À 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) parmit. Pages 1 and 2 should be till Department of Health and Mental Hy Important: if them 27 is merived oth any Injury or other traumatic even other. John Weakes Irene Berry 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C. Olivia Green/Granddaughter 5952 Cedar Fern Ct. 21044 Columbia, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Ocermation 3 Removal from State 4 Donation 5 Other (Specify) 9-13-00 Baltimore, Md. Metro Crematory Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of ND. Inc. Thomas I Thomas Gregor 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical ung Cancer Examiner Due to (or as e consequence of): Physician/Medical Examiner certificate has been signed by the attending physician and rector, page 2 should be detached for use as the bunal-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be execu Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown orexia by 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy Completed performed? 20 No 1 ☐ Yas 2 ☐ No 1□ Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: A Nursing Home 5 Residence 6 Other (Specify) Certification: To within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number 18 13, 2000 D50973 lina 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Two Knoll North Md JACOB CHERIAN Columbia 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 1 4 2000 Registrar

DHMH 16 Rev 6/95



mes Michael	L V	Vebster		State of M	/larylan		artment of rtificate o	f Health and I of Death		giene	0 8	29075		
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/Medical Examiner		a Facility Name (II		a street and number		002		4b. City, Town, or L				11.45 Mill		
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Pund Mand	-	Oa. State	10b. County	72	10c. Cit	y, Town or Lo	cation				1	Od. Inside City Limits		
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120  nr after death with the Marylar  r, or items 23e or 28e-f show  varriner must be notitled at  ov Furnarial Director	27 1 11110	Marital Status     Never Marri     Widowed	ied 2 Married	12. Was Deceder Armed Force 1 X Yes 2 [ If Yes, Give Year or Date:	No		Was Decedent of Yes, specify 0	of Hispanic Origin? (S Cuban, Mexican, Puert No <i>Specify:</i>	pecify Yea or No o Rican, atc.)	Blac	Day Year  12, 2000 11:45 A.M.  4c. County of Death  Talbot  9. Birthplace (State or Foreign County)  1951 Maryland  10d. Inside City Limits 1  Yes 2 No  Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify: White  D. Kind of Business/Industry  urniture  anufacturing  den Sumeme)  1e  ity or Town, State, Zip Code)  Ore, MD 21210  Location - City or Town, State  Baltimore, MD  , Inc.  imore, MD 21228  Approximate Interval Between Onset and Death  Onset and Death  2No 3 Probably 4 Unknown  uutopsy difference of death?  2No 1 Yes 2 No  e 6 Yother (Specify) at Scene injury occurred Shot self.			
od sales	-		15. Decedent's E			16a Dece	dent's Usual Oc	cupation		16b. Kind of Bu	usiness/în	dustry		
Maryland 21215-0020 d 2 should be filed within 72 hours at th and Martal Hyglene. 7 is marked other than "natural", or treatmetic event, the Medical Exam To Be Completed by 8		(Spec	ndery (0-12)	college (1-4c	r 5+)	(Give	kind of work do DO NOT use re	ne during most of wor. tired)	king	Furni	ture			
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Bud Hall	3	7. Father's Name (						18. Mother's Nen	ne (First, Middle	, Maiden Sumem				
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Mar alth and 27 is m or tream		19e. Informant's Name/Relationship (Type, Print)  19b. Meiling Address (Street end Number or Aural Route Number, City or Town, State Virginia Foster/Mother  4239 Wickford Road Baltimore, M												
permit. Pages 1 a Department of his Important, if item any injury or oth anse injury or oth		20a. Method of Disp 1 Durial 21 4 Donation 21. Signature of Fu	Cremation 3 ☐ 5 ☐ Other (Special Ineral Service Line)		Met	comatery, cred	sition (Neme of metory or other Cemator 2. Name and Ad remati	ry, Inc.	9/14/00 ty of	Balt:	imor	e, MD		
Physician /Medical Examiner		23a. Part 1. Enter the shock, or heal Immediate Cause ( disaase or condition resulting in death)	rt failura. List only Final	one cause on each	oral (		t Wound	dying, such as cardiac	or respiratory e	irrest,	1	Interval Between		
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P.O. nat the d dby the detached			epression	ontributing to death	but not res	ulting in the u	nderlying cause	given in Part I.						
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Of Vital Physician: The Physician: The satisficate real director, page Co.: To Be Co.:		25. Was case referrence exeminer?	red to medical					26. Place of Dea	ath (Check only	one)	1			
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SION O tending Ph tenth. tor: After th the funeral cation:		<ol> <li>Manner of Death</li> <li>Death</li> </ol>	5 Pending	Found:	njury De <i>y Year)</i>	Found		njury at Work?		how injury occur				
Attending or death.  Softer: After by the fune		2 ☐ Accident 3 🛮 Suicide	investigatio	09-12-	2000	11:10	A	1 X Yes 2 No						
DIVISION C but or Attanding P is after death. at Director: After t ed in by the funera Certification:		4 ☐ Homicide	determined	28e. Place of building,	injury - At h etc. <i>(Specil</i>	ome, farm, st	reet, fectory, officers	ICB				el Route Number, cyland Ave.		
DIVISION To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune Medical Certification		29a. Certifier (Check only		niner: On the basis	of examina	wledge, deet	n occurred at th	e time, dete and place ny opinion, death occu	, and dua to the		anner as s			
thin 2 mplet		one)		and manner										
or with		29b. Signatura and	- / /	1	-	-		onse number  O.C.M.E.		29d. Date signe Septembe				

31. Date filed (Month, Day, Year) SEP 1 4 2000

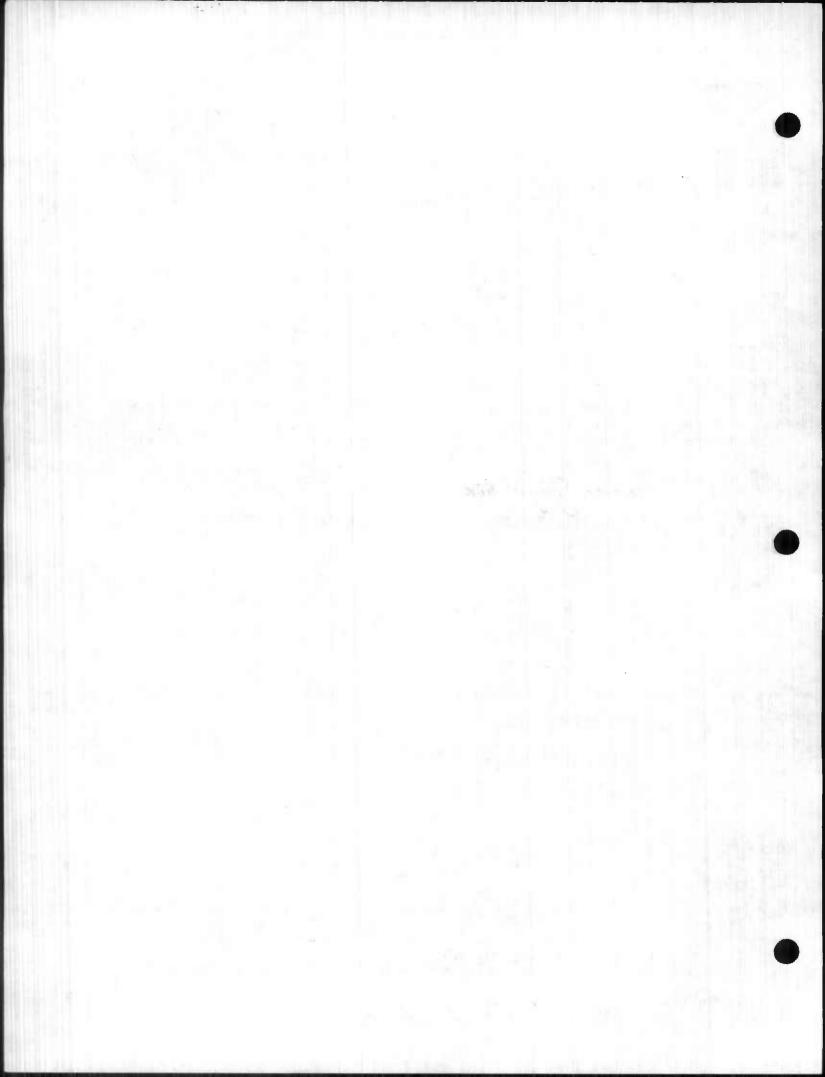
Mysh & Vlasty, M.A.

30. Name and address of parson who completed cause of death (Mem 23a) (Type, Print)
Stephen Radentz, M.D.

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

State Registrar

DHMH 16 Rev 6/95



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month CHARLES MOZTIMW 4.00 Pm SER 2000 06 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death HALBOR HOSPITAL BALTIMOLE N/A If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 6. Sax 7. Age (In yrs. last birthday) Birthpiece (State or Foreign Country) Months Days 11X M 2□ F 705 05 3428 Yrs. 99 May 16, 1901 West Virginia Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 W. 10th Avenue 21225 U.S. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Biack, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 X Never Married 2 ☐ Married 1 Yes 2 XNo Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8th Machinist B & O Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Minnie Zimmerman Frank Whitson 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) David Whitson Nephew 4722 Lavington Place Baltimore, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 9/12/00 Martinsbury, W. Virginia Green Hill Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Lipanne 22. Name end Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 not enter the mode of dying, such as cardiac or respiratory errest, 23a Part1. Enter the disease, or complications that calculate shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARRYTHMIA CARDIAC Due to (or as a consequence of): I week RENAL FAILURE WITH HYPERKALEMIA Due to (or as e consequence ot) 2 weeks PLERENAL AZOTEMIA Due to (or as e consequence ot) 23b. Did tobacco uss contributs to the causs of death? 1 Yss 2 No 3 Probably 4 Unknown MINOMINENIA

**Physician** /Medical Examiner

permit. Pages 1 and 2 st Department of Health and Important; if hen 27 is in any injury or other traum 2008.

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

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"netural", or flame 23s or r than "natural", or flams 23s or the Medical Examiner must be

filed within 72 hours after

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Baltimore, Maryland 21215-0020

Box 68760,

P.O.

Division of Vital Records.

Director

Funeral

by

Completed

attending physician and for use as the bunal-tran signed by the a page 2 should has this funeral After

Examiner Physician/Medical by Completed Be 2 Certification:

**DHMH 16 Rsv 6/95** 

The law requires that the death certificate be executed Physician: or Attending s after deam. al Director: After within 24 hours a
To the Funeral C

> State Registrar

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? COPD CHLONIC 1 Tyes 2 No 1 □ Yes 2 □ No ABRILLATION ATRIAL 25. Was case reterred to medical examiner? 26. Plece of Death (Check only one) Hospitel: 1 ⊠Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 5 Pending investigation 1 Naturat 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29e. Certifier (Check only one)

30. Name and address of person who completed cause ot death (Item 23a) (Type, Print) GAVIAM BANDEEL 31. Dete tiled (Month, Day, Year) SEP 1 4 32. Registrar's Signature

M.D.

HOSPITAL HARBOR

BALTIMORE, MD 21225

CEP

29d. Date signed (Month, Day, Year)

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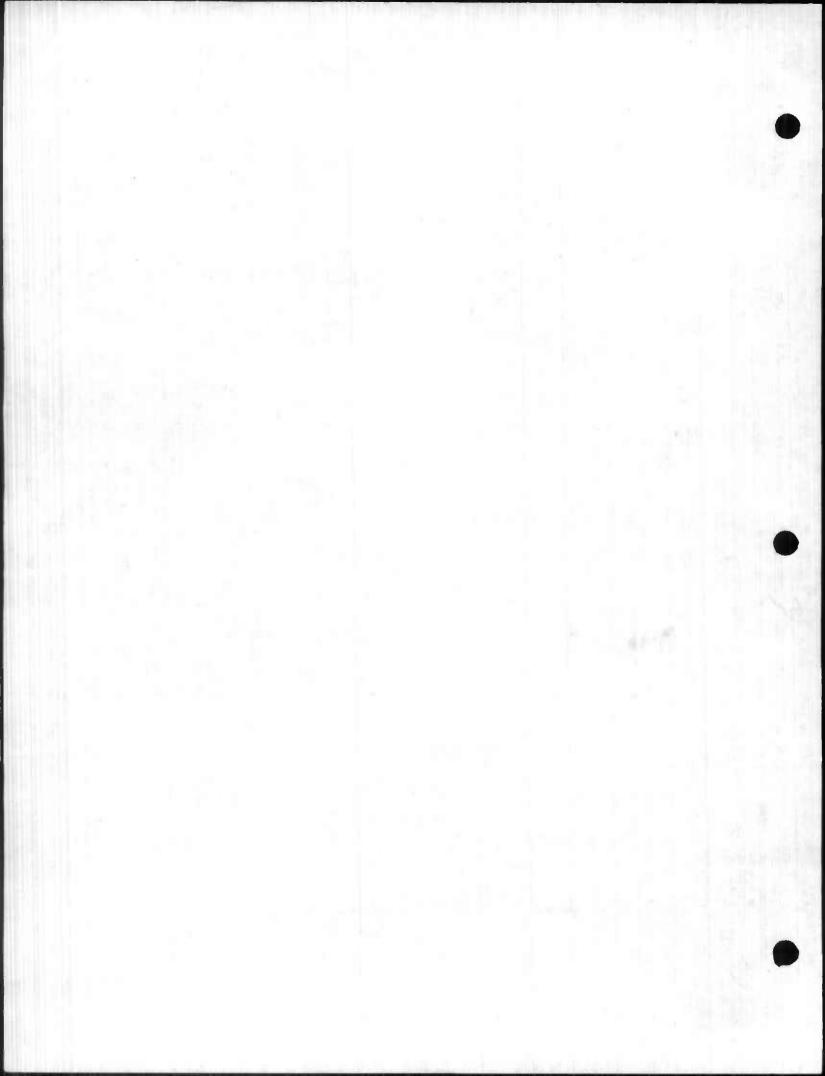
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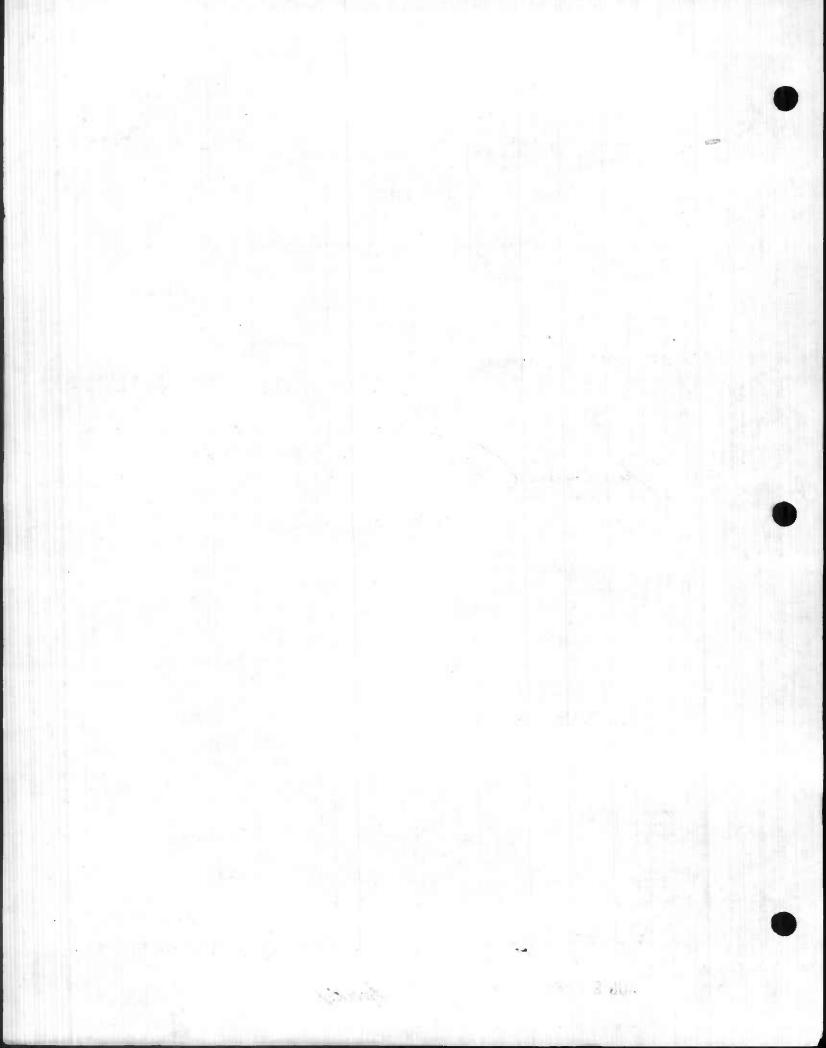
29b. Signature and title of certifier

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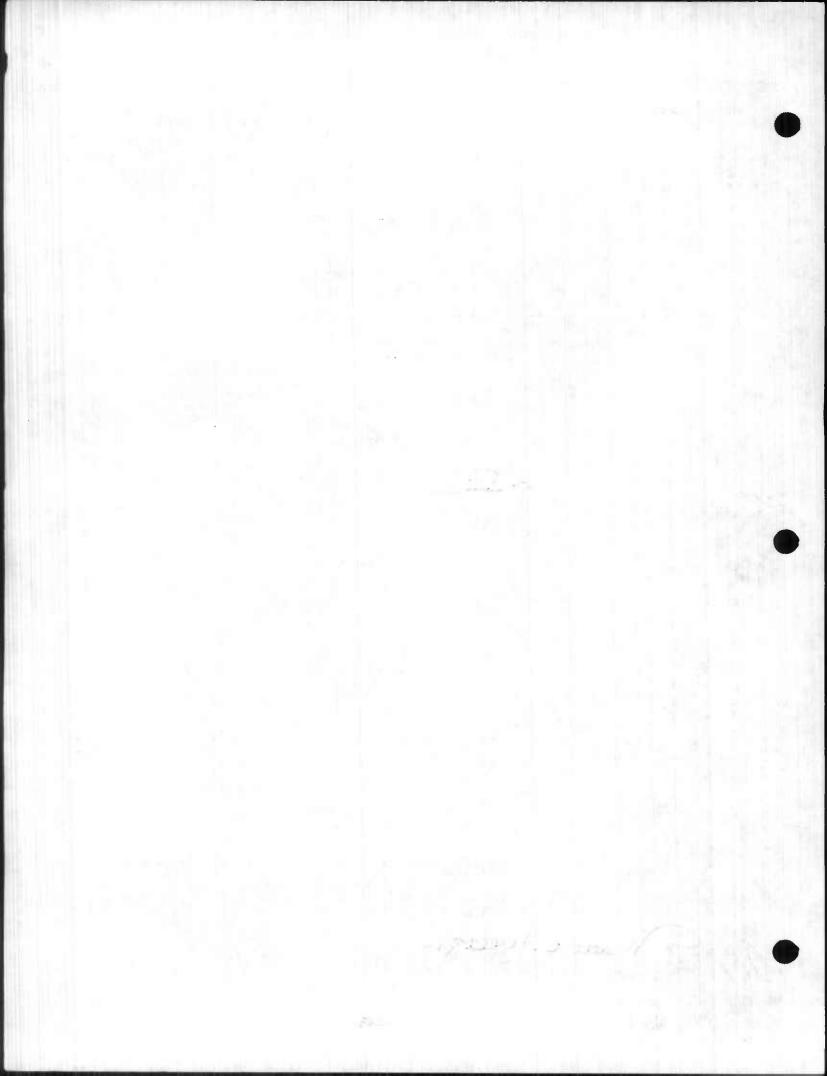
amend item	19a per informant G788	State of Maryla 10/19/00 yf		rtment of h tificate of		Mental Hy	rgiene (	29077				
Physician /Medical	Decedent's Name (First, Middle, Las     Jacquel		dams			2. Date of Do Month Aug.	20th 2	3. Time of Death 2000 3:10p.m				
Examiner	4a Facility Name (If not institution, give Fox Chase Nur					Sprin	g Mont	of Death gomery				
Funeral Director	5/8-34-2/32	7. Age (In yrs	74 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Dete of Bi (Month, Di 12/4/2	rth ay, Year) 5	9. Birthplace (State or Foreign NEW YORK, NY				
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herne Dec.m	11. Merital Status SINGLE**	12. Was Decedent Ever in Amed Forces? 1 Yes No If Yas, Give Year or Detes:		Ves Decedent of P Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	o- 14. Rac Bled Specify	e - American Indien, k, White, etc. BLACK				
Maryland 21215-0020 d 2 should be filed within 72 hours at th and Mental Hygiene. T is marked other than "natural", or traumatic event, the Medical Exemy To Be Completed by F	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12 YEARS	college (1-4or 5+) 4 YEARS	(Give k	O NOT use retire	during most of work		16b. Kind of Business/Industry FEDERAL GOVERNMENT OR)					
semit. Pages 1 and 2 should be file semit. Pages 1 and 2 should be file appartment of Meatile and Mentile Hy mportant; if Nem 37 is marked othe iny injury or other traumatic event. Digs.  To Be C	17. Father's Name (First, Middle, Last) HERBERT ADAMS	, Maiden Sumam	Θ)									
	19a. Informant's Name/Ralationship (TFREDA L. ADAMS /	ype, Print) Sister	19b. Mailing 2541	7TH AVE	NUE, #10D	NEW Y	ORK, NY	Stele, Zip Code) 10039				
	20a. Method of Disposition  1 X Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Nama of cemetery, crematory or other place)  MT OLIVET CEMETERY  20c. Location - City of Cemetery, crematory or other place)  WASHINGTON											
Demit Depart Imports any In)	21. Signeture of Funeral Service Licego	9°. #C20272			T. Rhine			C. 20017				
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shounder of the state of the st	DEMEN	TA					s en eutopsy ormed?	24b. Ware autopsy findings available prior to completion of cause of death?				
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_ 2 0 0	27. Manner of Death 1 SNatural 5 Pending	Hospitel: 1 Inpatient 2[ 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Inju	her: 4/2 Nursing Ho	ome 5 Ras	idence 6 Oth					
DIVISION C bell or Attending P is effer death. el Director: After t led in by the funera Certification:	2 Accident 3 Suicide 4 Homicide	28e. Plece of Injury - At I building, etc. (Spec	home, ferm, stre		7145 20110		(Street and Numb wn, Stata)	er or Rural Route Number,				
Hospita 14 hount Funers tely fille	29a. Certifier Chest of Examiner: To the best of my knowledge, death occurred at the time, data end place, and due to the causa(s) and manner as at Chest or 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data end place, and due to and manner steed.											
To the within 2 To the comple	290. Signature and title of certifier			29c. Licens				d (Month, Day, Year) T, 23, 2000				
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 0 29078

		Certificate of Deal	th	Reg. No.	2010					
		Decedent's Name (First, Middle, Last)	2. Data of De Month	ath Day Year	3. Time of Death					
	Physician /Medical	VADI D ADMED	AUGUST		00 10:10 AM					
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	or 2	10a. Street and Number		10g. Citizen of What Co	ountry?					
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	for death v	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  1 □ Never Married  12. Was Decedent Ever in U,S. Armed Forces?  1 □ Yes 2 □ No	tican, Puarto Rican, etc.)	No- Black, White, etc.						
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pu	正工七 5 6	17. Father's Nama (First, Middla, Last)	lother's Name (First, Middle,	Maiden Sumame)						
yla	2 sho	KARL A. ABNER ETH	HEL S. LAWF							
Mar		19a. Informant's Name/Relationship (Type, Print)  19b. Meiling Address (Street and Nut								
-	f Health tem 27 other tr	ROSE ABNER/ SPOUSE 8274 AHEARN DR.  20a. Method of Disposition 20b. Place of Disposition (Name of	. MILLERSVI	LLE, MD. 2 20c. Location - City or						
יסנ	80 - 40 U	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cematery, crematory or other place)								
Baltimore		4 Donation 5 Other (Specify)  LAKEMOUNT CEMETER:		00 DAVIDS	ONVILLE MD.					
Ba	Department in moorts any Inje	21. Signature of Funeral Service Licensee 22. Name and Address of Fa	BEALI	FUNERAL	HOME					
15	2	KYLE SIMONS M01206 6512 N.W. CH	RAIN HWY. F	BOWIE, MD.						
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heert feilure. List only one ceuse on each line.	h as cardiec or respiratory a	rest,	Approximate Intervel Between Onset and Death					
	Physician /Medical	Immediate Cause (Final								
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	0 00 0	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part II.	he underlying cause given in Part I. 23b. Dld tobacco usa contributa to							
P.0	es that the de igned by the a be detached?		10	Yee 2 No 3 P	Probably 4 Unknown					
JS,	law requires that the as been signed by the 2 should be detach oppleted by Physical		04-144	an autopsy 24b.	. Were autopsy findings					
Records,	The law require sate has been si page 2 should Completed			omed?	available prior to completion of cause					
360	has be so mpl				of death?					
alF	cate har.			Yes 2 No	1 ☐ Yas 2 ☐ No					
Vital	certificate rector, pag	examiner? Hospital: Other	Place of Death (Check only							
ot	hys log	1 I Tas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4L	Nursing Home 5 Resi	dence 6 LiOther (Spe how injury occurred	ecify)					
uo.	After After funer funer	27. Menner of Death 28a. Date of Injury 28b. Time of Work? 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation 4 M M								
Division	after death, Director: After d in by the fune	2 Accident Investigation 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office		Street and Number or R	Rural Route Number,					
Ö	2 5 5 E	4 Homicide  5 Home, farm, street, factory, office building, etc. (Specify)	City or To	wn, State)						
	Hospital or 24 hours after Funeral Dir stely filled in		e and piece, end due to the	cause(s) and menner a	as stated.					
	To the Mospital Minim 24 hours a fro the Funeral Completely filled Medical Ce	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	death occurred at the time,	dete end plece, and du	e to the cause(s)					
	within 2 We the bomple		ber	29d. Date signed (Mon	nth, Day, Year)					
	(10)	D23743	1.23	08-25-200	0					
	(10)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								
		DR. MARTIN D. WETZ 7525 GREENWAY DRIVE G	GREENBELT,	MD. 20770						
	State	31. Dete filed (Month, Day, Year) 32. Registrar's Signature								
	Registrar	AUG 2 8 2000 Janes 10. Aparts								



State of Maryland / Department of Health and Mental Hygiene

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0	U	2	9	U	1

			C	ertificate d	of Death	7		Reg. No.	0	23013
4 I L	1. Decedent's Nama (First, Middle, La	st)	4				2. Data of Dea Month	nth Day	Yaar	3. Time of Death
Physician // // // // // // // // // // // // //	Nancy R. Atk	inson			AUGUS'			09:01 A.M		
Examiner	4a Facility Name (If not institution, give	own, or Loc	cation of Death	4c. County	of Death					
	DOCTORS HOSPIT					ANHAM				EORGE'S
Funeral Director	5. Social Security Number 6. S 239–78–0708		s. last birthda 55 Yrs.	y) If Under 1 Y Months Da	aar If Unda ays Hours	r 24 Hrs. Min.	8. Data of Birth (Month, Day APTIL /	, Year) 945	9. Birthpi Coun Johns	lace (State or Foreign stry) Son Cty.N.
pur *	10a. Stata 10b. County	10c. C	City, Town or	Location					11	0d. Inside City Limits
or death with the Marylan Nerma 23s or 28s-1 show the most be notified at uneral Director	Maryland Prince	George's	Largo	10f. Zip Coo	la.			10g. Citizen of V	What Coun	1 ☐ Yas 2 ☐ No
a 23¢ or	500 N. Harry S.			20	774	1-1-0 (0		United		es
ar. or	11. Marital Status  1 Nevar Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Evar in Armed Forcas?  1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas:	0,5.	3. Was Decedent If Yas, specify ( 1 Yas 2			city tas or No- Rican, atc.)	Blac	ck, White,	atc.
ed within 72 hours ygiene. wr then "neturel", it, the Macing Ext.	15. Decedent's Ed (Specify only highest gre	ducetion ada completad)	16a. Dec	cedant's Usuaf Oc va kind of work do . DO NOT usa ra	cupation ona during mo	st of working	ng	16b. Kind of B	usinass/Ind	tustry
within she.	Elementary/Secondary (0-12)	Collega (1-4or 5+)						D C D	h140	Schools
	12		FO	od Handl	1	- de Nassa	Fina Middle			2010018
Saby W	17. Fathar's Nama (First, Middla, Last,							Maidan Suman	18)	
should by marked umatic ex	Roosevelt While		400 14	W A 44 (O			er Howe		On to Ti-	0-4-1
d 2 sho th end 7 le m traum	19a. Informant's Name/Refationship (					oral Routa Number, City or Town, Stata, Zip Coda) 01 Washington, D.C. 20019				
CHUF	Reginald Atkins 20a Mathod of Disposition			D. Stre		. #10	Data	20c. Location -		
emit. Pages 1 a Pepartment of Hei mportant: if Hem ny Injury or othe MGS.	1   Buriaf 2   Cramation 3   Mamoval from Stata   Commeten, Cramatory or other place)   Everett Cemetery   9/2/2000   Wayne Cour									
permit. Pag Department Important: b any Injury o	21. Signature of Funaral Sarvice Licer	1500 MIG8				-		l Homes	Md.	20747
	23a. Part1. Entar tha disaasa, or com shock, or haart failura. List only	plications that caused the de	ath. Do not a	ntar tha moda of	dying, such a	s cerdiac o	r raspiratory ar	rest,		Approximate Interval Between
death certificate be axecuted eatherding physicien and of lor use as the burial-transit sician/Medical Examiner	Sequantially fist conditions, if sny, leading to immadiata ceusa. Entar Undarrying Cause (Disease or injury that initiated avents rasulting in death) Last	b. Ruptur of Due to	(or as a cons	equance of):	scular	ion Di	Seasi			
the death cert y the attending sched for use a	Part II. Other significant conditions of	ontributing to death but not re	asulting in the	undariving caus	a given in Part	I.	23b. Dld 1	obacco usa co	ntributs to	the cause of death?
es that the death or igned by the attend be detached for us by Physician/	Diabetes melli							Yss 2 No	3 Prol	
v requir been s should	Status post kidney		or chn	our roud	insuf	Freen	24a. Was perio	an autopsy med?	ava	ara autopsy findings ailable prior to impletion of cause death?
Physician: The law requires tribis certificate has been signs rail director, page 2 should be rail or De Completed by							100	es 2□No	15	Yas 2□ No
Sentific extor	25. Was cese referred to medical axaminar?	Allandani				ce of Death	(Check only o	na)		
this aid	1	28a. Data of Injury (Month, Day Year)	ZER/Outpat 28b. Time Injury	of 28c.	Other: 4 North Nor	2		dence 6 Oth	1-1-1-1	γ)
er Edag	3 Suicida 6 Could not b datarmined	28a. Place of Injury - At building, atc. (Spec	homa, farm,	straat, factory, of	ice	2	28f. Location (S City or Tox		ber or Aura	al Routa Number,
Hospi M hou Funer Hely fill	29a. Cartifiar (Checkonly one) 1 Certifying Ph	ysician: To the best of my kr niner: On the basis of axamir and manner stated.	nowledga, da nation and/or	ath occurred at the invastigation, in a	e time, date s my opinion, de	and place, a path occurre	and due to the ed at tha time,	cause(s) and m data and place,	annar as si and dua to	tated. tha causa(s)
To the To the Comple	29b. Signatura and title of certifiar			29d. Data signad (Month, Day, Year)						
(10)	30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print)							AUGUS	ST 27	,2000
0	Dennis Chi	ite no	111 Pe	nn Stree	et, Bal	timor	e, Mary	yland 2	1201	
State Registrar	31. Data filed (Month, Day, Year) AUG 2 9 2000	32. Registrar's SIg	natura	Louis	61					

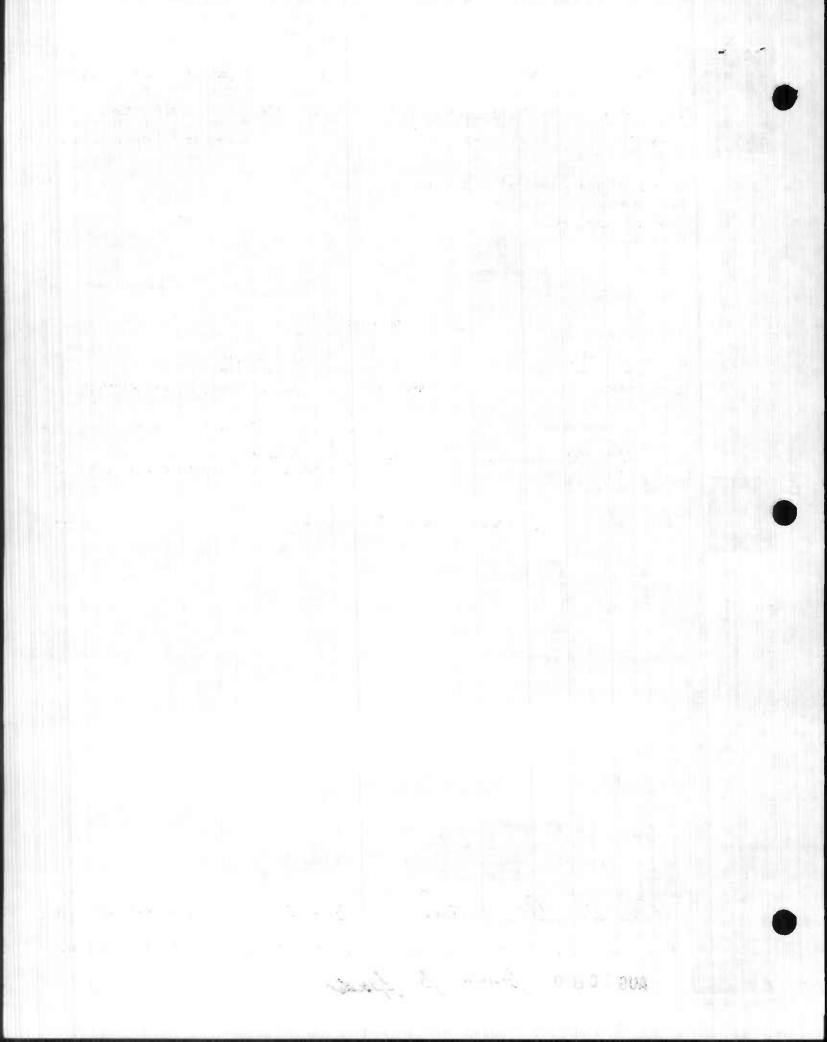
DHMH 16 Rev 6/95

Registrar

State of Maryland / Department of Health and Mental Hygiene

				Certificate of	f Death		Reg. No.	29080		
	1. Decedent's Nama (First, Middle, La	2. Date of De	eath 3. Time of Dea							
Physician /Medical	Vivian A	ddison					24, 200			
Examiner	4a Facility Name (If not institution, give	e street and number)			4b. City, Town,	, or Location of Deat	h 4c. County	of Death		
Funeral Director	Gladys Spellman Sp 5. Social Security Number 6. S 053-30-7325  Usual Residence of Decedent		Sp.& Nu In yrs. last bi		ar   ff Under 24	Min. 8. Data of Bir	th ey, Yeer)	George's  9. Birthplace (State or Foraign Country)  6 Baltimore, MD		
pue *	10a. State 10b. County	1	Oc. City, Tow	m or Location				10d. fnslde City Limits		
ith the Meryler or 28a-f show a notified	Maryland Prince 0	George's	Clinton					1 ☐ Yes 2 ☐ No		
Unter death with the Me inter death with the Me inter rust be notified funeral Director	10e. Street and Number 5900 Den Lee Driv	re		10f. Zip Cod 20735			USA	What Country?		
5-0020 72 hours after death with the Meryland natural; or Items 23a or 28a-f show area Examined manual Examined an ested by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Even Armad Forces?  1  Yes 2 No H Yes, Give Yaar or Dates:	er in U,S.	13. Was Decedent of it Yas, specify C		? (Specify Yes or No uerto Rican, etc.)	Bla	e - American Indian, ck, White, etc.		
72 hours	15. Decedent's E (Specify only highast gra		16a	. Decedent's Usual Oc (Give kind of work do	cupation ne during most of	working .	16b. Kind of B	usinass/industry		
withir ene.	Elementary/Secondery (0-12)	College (1-4or 5+)		(Give kind of work do life. DO NOT use rei Bartender			Priva	te		
be file to the sysmt,	17. Fathar's Name (First, Middla, Last	)			18. Mothar's	Name (First, Middle	, Maiden Surnen	10)		
Maryland 2 d2 should be filed h and Mentel Hygi 7 is marked other treumatic svant, To Be Co	Luther McArthur t9a. Informant's Name/Relationship	Type Print)	198	b. Mailing Address (Str.		an Burgess		Steta, Zio Coda)		
Ma dd2 s dd2 s ff har trau	Shanz Booker / Da			900 Den Lee						
ges 1 end 2 it of Health if item 27 i	20a. Method of Disposition	agneer	20b Place C	of Disposition (Neme of		Date		City or Town, State		
F P P P P	1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	(y)	Fort 1	Lincoln Cre	matory	8/29/00	Brentwo	od, Maryland		
Balti permit. Deportu importu any ink	23a. Pert1. Emerthe disease, or comshock, or heart tellure. List only		e death. Do	22. Name and Ad Fort Lind 3401 Blace not enter the mode of	oln Fund	Road Bren	ntwood,	Maryland 20722 Approximate Interval Between Onset and Death		
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting In death)	(		, year						
requires that the death certificate be executed seen signed by the ettending physician and hould be detected for use as the burial-transit eted by Physician/Medical Examiner										
P.O. BOX at the death ce dby the ettendi eteched for use Physician/	Part II. Other significant conditions of	d	not resulting	In the underlying couse	given in Part i.	23b. Did	Did tobacco uss contribute to the cause of de			
is, P.O. es that the de gened by the be deteched by Physical by Ph			717			1 🗆	Yes 2 No	3 ☐ Probably 4 ☐ Unknown		
D 2 5 5						24a. Was	s an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause ot deeth?		
						1 🗆	Yes 2 No	1 ☐ Yas 2 ☐ No		
Vital I	25. Was cese reterred to medicel			109	26. Place of	Death (Check only	one)			
of Vita Physician: rhis certific oral director,	examiner?	Hospital:	2□ER/O	utpetient 3 DOA	Other: 4 Nursi	ng Home 5 ☐ Res	Idence 6 Oth	ner (Specity)		
Ing After function	27. Manner of Death 1 Asturel 5 Pending 2 Accident Investigatio		'ear) 28b.		njuryat Vork? □ Yes 2 □ No		how injury occur	red		
Division at or Attended in Director. and in by the Certificat	3 Suicide 6 Could not b		ce		(Street and Numi wn, Stete)	ber or Rurel Route Number,				
Hospi 4 hou Funer tely fill		nysician: To the best of r miner: On the basis of ex and manner state	caminetion er							
To the within 2 To the comple	29b. Signature and titla of certifier	Owne	cus	29c. Lic	anse number a 181	r2	29d. Data signe	T 25 2000		
(3)	PAUL A. DEV	completed cause of deal	th (Item 23a)	(Type, Print) Queenss	sey fol	Hyaris	ville A	10 20181		
State Registrar	31. Date tiled (Month, Dey, Year)  AUG 3 0 2000	32. Registrar's	Signature 6.	Soud.	,					

DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene

U I	Decedent's Name (First, Middla, Last	p()	001	tificate of	D 00111	2. Date of D		V-	3. Time of Death			
hysician	John Walter	Armiger				Augus	Dey st 26, 20	Year 000	8:23 P.M.			
/Medical xaminer	4e Facility Nama (If not institution, give	street end number)	Arten	10 5 43	4b. City, Town, o	r Location of Dear						
	1639 Taylors Is				Woolf		Dorch					
neral ector	5. Sociel Sacurity Number 219-03-1964  Usual Rasidance of Decedent	ex 2	rs. last birthday) Yrs.	Months Days			ay, Year)		lace (Stata or Foreign try) 'yland			
ž u	10a. State 10b. County	10c.	City, Town or Loc	cation				10	0d. Inaide City Limits	-		
iner must be notified as Furneral Director	Maryland Dorches	ter	Woolfor	d					1 □ Yas 💥No			
Director	10e. Street and Number			10f. Zip Code			10g. Citizan of V		try?	Ī		
	1639 Taylors Isla				677		US					
by Funeral	11. Merital Stetus  1 Nevar Married 2 Married  XXVidowed 4 Divorced	12. Wes Decedent Ever in Armed Forces?  XX Yas 2 □ No If Yas, Giva Yaar or Detas:		Vas Decedant of Yas, specify Cul	Hispenic Origin? (ban, Maxican, Pus	(Specify Yes or Narto Rican, atc.)	o- 14. Race Blec Specify	Bleck, Whita, etc.				
pleted	15. Decedent's Ed (Specify only highast gra Elementary/Secondary (0-12)	ucation da completed) College (1-4or 5+)	16a. Deced (Giva I lifa. C	Decedent's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired)  16b. Kind of Business/Industry								
Comp	11	College (1-401 54)	Con	sulting	Engineer		Petro					
Be	17. Fathar's Nema (First, Middle, Last)						a, Maidan Sumam	a)				
70	Joseph Griffith					Harcour						
	19a. Informant's Name/Ralationship (1				and Number or i							
	John W. Armiger, 20a. Mathod of Disposition	OLOTA City or To	do 80477									
	1  Burial 2 □ Cremetion 3 □ 4 □ Donation 5 □ Othar (Specify	namover from Stata	cematary, cram	ity Chu	eca) rchyard	8/30/00			, Maryland			
	21. Signatur of Funeral Service Moon 23a. Padr. Enter the disease, or com	n	Th 70	0 Locust	neral Hom t Street	Cambride		land	21613 Approximate			
n al er	shock, or haart failura. List only immediata Causa (Finel disaasa or condition rasulting in death)	ona causa on each lina.  Intraoral		Wound				1	Intarval Between Onset and Death			
Examiner	Sequentially list conditions,	bDua to	o (or as a conseq	uance of):				İ		_		
Medical	that initieted events rasulting in death) Last	Due to	(or es a consequ	uance of):			H 113					
Physician/M	Part II. Other significant conditions or	ontributing to death but not i	rasulting in tha un	derlying cause g	iven in Part I.	23b. Did	Did tobacco use contributs to the causs of death?					
						10	Ysa 2 No	3 Prot	bably 4 Unknown			
Completed by						24a. Wa per Part	s an autopsy formed?	COI	ara autopsy findings ellable prior to mplation of cause death?			
mo.						12	Yas 2□No	12	Yas 2 No			
Be	25. Was case refarred to medical examinar?				28. Place of D	eath (Check only	ona)					
To	examinar? 1 X Yas 2 No	Hospital: 1 ☐ Inpatiant 2	□ ER/Outpatien	I JLI DOA			sidanca 6 Oth		at scene			
	27. Mannar of Death  1 Natural 5 Pending	Found: Day Year	28b. Tima of Injury	28c. Inj			how injury occur					
Cat	2 Accident Invastigation 3 N Suicide 6 Could not be	08-26-2000	6:40 F	,	Yas 2 No		t shot s		I Routa Number			
Certification:	4 Homicide datamined	building, atc. (Spe	At ho	ome		Island		olfor	nd, Maryland			
Medical Certi		valcian: To the best of my liner: On the basis of axam and mannar stated.										
2	29b. Signature and title of certifier	1 1			nsa number	29d. Deta signed (Month, Day, Year)				•		
1	1//	nd, mil	,	0	.C.M.E.		August	27,	2000			
	30 Name and address of threson who a	ompleted object of death ()	- Partie		Street.	Baltimo	re. Marv	land	21201			

State Registrar

SEP 0 1 2000

SEPT LZORT JOHN D. JANES

FREDERICK BETHEA

State of Maryland / Department of Health and Mental Hygiene AMEND ITEMS: #23 PART I, 27, PER MEO Certificate of DeathWR. 2. Data of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Yaar **Physician** Frederick Allen Bethea 15 **AUGUST** 2000 12:40 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 46873 FLOWER DRIVE LEXINGTON PARK ST. MARY'S If Undar 1 Year If Under 24 Hrs. 5. Social Security Number 6. Şex M 2□ F 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Months Days Hours 243-90-3043 Yrs. 44 Director 1956 North Jan Carolina Usual Rasidance of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Harris 23s or 28s-f show MD St Marys Lexington Park 1 ☐ Yas 2 € NO Directo r than "natural", or itams 23s or 28s-the Medical Examiner must be notifi 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 46873 Flower Drive 20653 USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedant of Hispanic Orlgin? (Specify Yea or No If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indian, Black, White, etc. 72 hours after TETNEVER Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Electrical Engineer 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) should be filled within Elementery/Secondary (0-12) College (1-4or 5+) Commerical 5 plus 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental Allen Dicks marked Juanita Bethea ormit. Pages 1 and 2 sh.,
Department of Health and Is,
Important: If Item 27 is se any injury or oth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 1123 South 8th St Wilmington NC 28401
Date 20c Location - City or Town, State Mrs. Mary Bethea 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 8/22/00 Calvary Cemetery Wilmington NC 28401 21. Signature of Funeral Service () 22. Name and Address of Facility Jordan Funeral Home POB 930 Wilmington NC 28402 B. or Complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, the only one ceuse on each line. Approximate interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting In death) /Medical PNEUMONIA Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be axecuted use as the burial-transit Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last and Due to (or as a consequence of): Box 68760. been signed by the attending physician should be detached for use as the buria Physician/Medical Due to (or as a consequence of): P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part ii. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 SLinknown Division of Vital Records. py 24b. Wera autopsy findings available prior to completion of cause of death? page 2 should Completed 24a. Was an autopsy performed? this certificate has Y Yes 2 No Wayes 2□ No Physician: eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) SCENE 1 XYes 2 □ No 27. Manner of Death 1 X Natural 28d. Describe how injury ocurred 28a. Dete of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 5 Pending investigation Attending 1 | Yes 2 | No death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) or A after 4 Homlcide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29c. Licensa number 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifier O.C.M.E. AUGUST 16, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

**DHMH 16 Rav 6/95** 

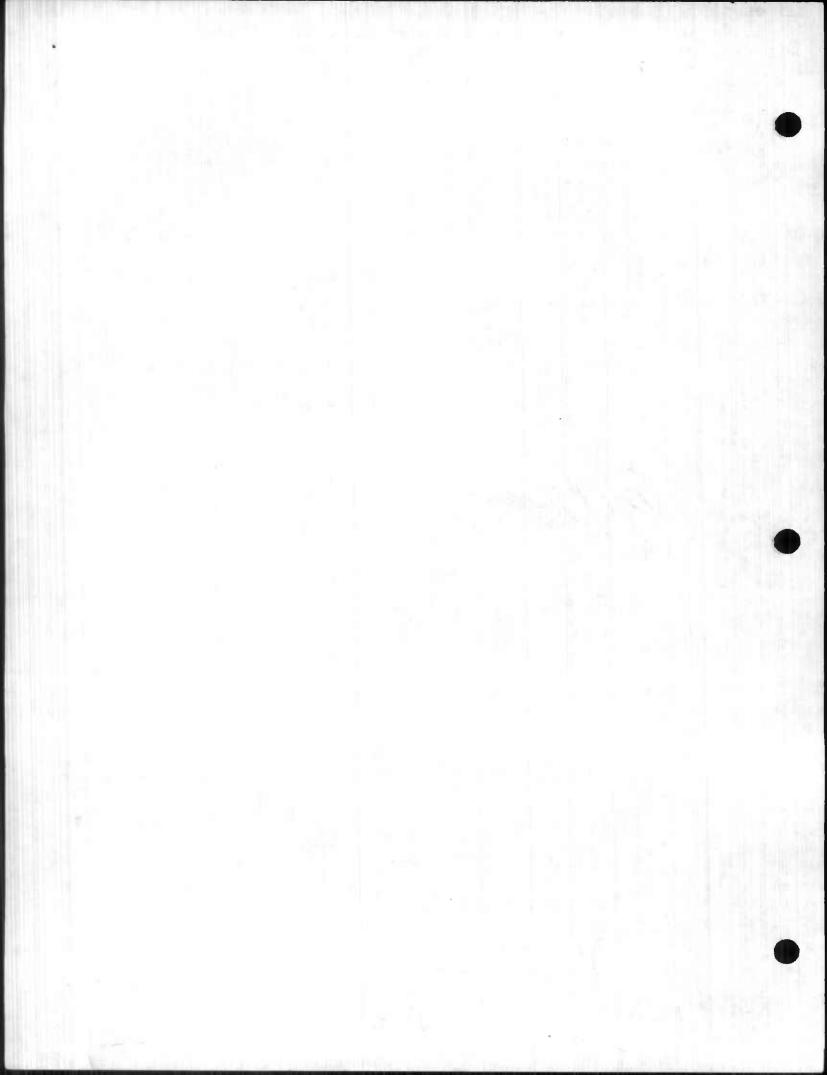
State

Dennis Chute M.D.

31. Date filed (Month, Day, Year) AUG 1 8 2000

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene

29083

				Cer	tificate o	of D	eath		Reg. No.					
	1. Decedent's Nama (First, Middla,							2. Dete of D		Year	3. Time of Death			
Physician /Medical	Claire Salome E	olbecker .						August	25 <sup>Day</sup> 200	0	8:15 a.m			
Examiner	4a Facility Nama (If not institution, 867 Mt. Airy Ro		ber)	rie-			. City, Town, o avidson	Location of Dea	th 4c. County Anne		del			
Funeral	5. Social Security Number	6. Sex 7	. Aga (In yrs. las	birthday)	If Under 1 Y		If Under 24 Hr Hours Mir		irth	9. Birth	place (Stata or Foraign			
Director	579-01-7246 Usual Rasidence of Decedent	1□M 2ÅF	95	Yrs.	Months	ays	nouis Mir		12, 1905		nnsylvania			
of show fiedat tor	10a. State 10b. County	Arundel	10c. City, T		cation	Δ				1	10d. Inside City Limits 1 X Yas 2 No			
be notified Director	10e. Street and Number	III dilde		uv Lui	10f. Zip Cod		91100	9 7,44 6	10g. Citizen of What Country?					
	867 Mt. Airy R	oad				21	.035		Α.					
sper mant sper mant Funeral	11. Meritei Status	12. Wes Deced	dant Evar in U,S.	13.	Vas Decedent			Specify Yes or N irto Rican, atc.)		e - Americ	can Indian,			
by	1 Nevar Merried 2 Marrie 3 Widowed 4 Divorced	Armed Ford  1  Yas 2  If Yas, Giva  Year or Del	2 🕅 No		TYas, specify to		Specify:	nto Rican, atc.)	O Rican, atc.)  Black, White, etc.  Specify:  White					
ted te	15. Decedent's			6a. Deced	dent's Usual Oc	ccupati	tion	ad in a	16b. Kind of B	usina <i>ss/</i> In	idustry			
Be Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1~	4or 5+)	lifa. L	DO NOT usa ra	itired)	iring most of w	UKING						
no	8	555g0 (1-		Ac	counta	nt			Treasu	ry D	epartment			
96	17. Fether's Name (First, Middle, Li	951)		-74		1	18. Mothar's Na	ame (First, Middl	e, Maiden Suman	10)				
To	John N. Eg	enrieder				Catherine Brickner								
	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Addrass (St	reet an	nd Number or F	Rural Routa Num	ber, City or Town,	State, Zip	o Coda)			
	Beverly A. Will	iamson - 1	Niece	867 N	At. Air	y R	Road, Da	avidsonv	ille, MD	21	035			
	20a. Mathod of Disposition		com	e of Dispo	sition (Name o	nless	)	Data	20c. Location	City or To	own, Stata			
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	4 Donation 5 Other (Specify) Fort Lincoln Cemetery 8/28/2000 Brown 21. Signature of Funeral Service Licensee 22. Nema and Address of Facility									ood,	marytand			
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al Examiner	Sequentially list conditions, if any, laading to immadiata		Dua to (or as	s a conseq	uence of):									
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	- wen you	uju								,				
/	30. Name and address of Werson w Peter M. Schiss					iter	r Drive	#430, 0	Greenbelt	, MD	20770			
State	31. Data filed (Month, Day, Year) AUG 2 8 20	08 32/Re	gistrar's Signatur	4	1-	,								
Registrar	NOU NO LO	00	1	0	AND DESCRIPTION OF THE PERSON NAMED IN	m								

Registrar

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 11/1-2. Date of Death 1. Decedent's Neme (First, Middle, Last) 22, 2000 **Physician** AUGUST THEODORE BRADLEY. 10:37PM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death **Examiner** PRINCE GEORGES COUNTY SOUTHERN MARYLAND HOSPITAL CENTER CLINTON 7. Age (In yrs. last birthday) If Undar 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day) Hours Min. JUNE 7, 1924 9. Birthplace (State or Foreign **Funeral** XXX 20F 301 242-20-3076 NORTH CAROLINA Director Usual Rasidence of Decedant n. Stata 10b. County MARYLAND PRINCE GEORGES 10d. Inside City Limits 10c. City, Town or Location XXXYes 2 No FORESTVILLE 10a. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 2300 TIMBERCREST DRIVE 20747 UNITED STATES 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes X2X No If Yas, Giva Yaer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-ff Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status 1 Nevar Married Sty Married 1 ☐ Yas X2CXNo Specify. Specify: AFRO-AMERICAN þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry (PRIVATE) 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AIR CONDITIONING/REFRIGERATION MECHANIC 2YEARS 12TH 18. Mother's Nama (First, Middla, Maidan Sumama) 17. Father's Nama (First, Middla, Last) Pages 1 and 2 should be in ment of Health and Mental Intel Item 27 is marked or BRADLEY, SR. JOHN EVELENA MOSLEY BRADLEY 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) ETHELINE J. BRADLEY/WIFE 2300 TIMBERCREST DRIVE, FORESTVILLE, MD 20747 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Date XIX Murial 2 Stamation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of uneral Service (Service) MRMONY MEMORIAL PARK CEM. 8-29-2000 LANDOVER, MD 22. Nama and Addrass of Facility **DUDLEY FUNERAL HOME** 3200 RHODE ISLAND AVE., MT. RAINIER, MD 20712 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such es cardiec or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death Physician /Medical Immediata Ceusa (Final model disaasa or condition rasulting in death) Examiner Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Physician/Medical Due to (or as a consequence of): Part ff. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably PSUnknown 24b. Wara autopsy findings available prior to completion of causa of death? Be Completed 24a. Was an autopsy 1 Yas 2/200 1 ☐ Yas 2 ☐ No 25. Was casa referred to medical 26. Placa of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas 2 No 27. Manner of Death 28b. Tima of 1 Natural 5 Pending 1 Yas 2 No invastigation 2 Accident 6 Could not be 3 Suicide 28e. Plece of Injury - At homa, farm, street, factory, offica building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Steta) To the Hospital within 24 hours To the Funeral 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, deta and piece, end due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, deta and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b. Signatura and the of certifier 29d. Date signed (Month, Day, Year) s of person who completed cause of daath (Itam 23a) (Type, Print)

Registrar

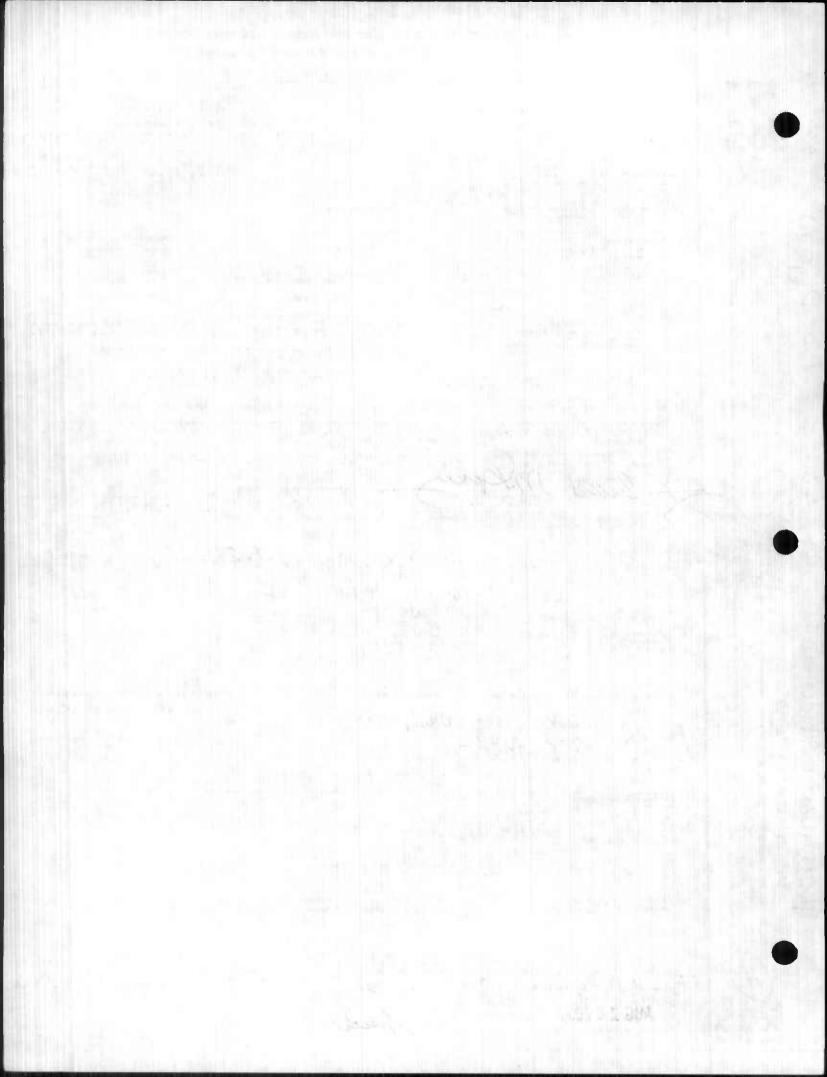
**DHMH 16 Rev 6/95** 

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62. Registrar's Signature

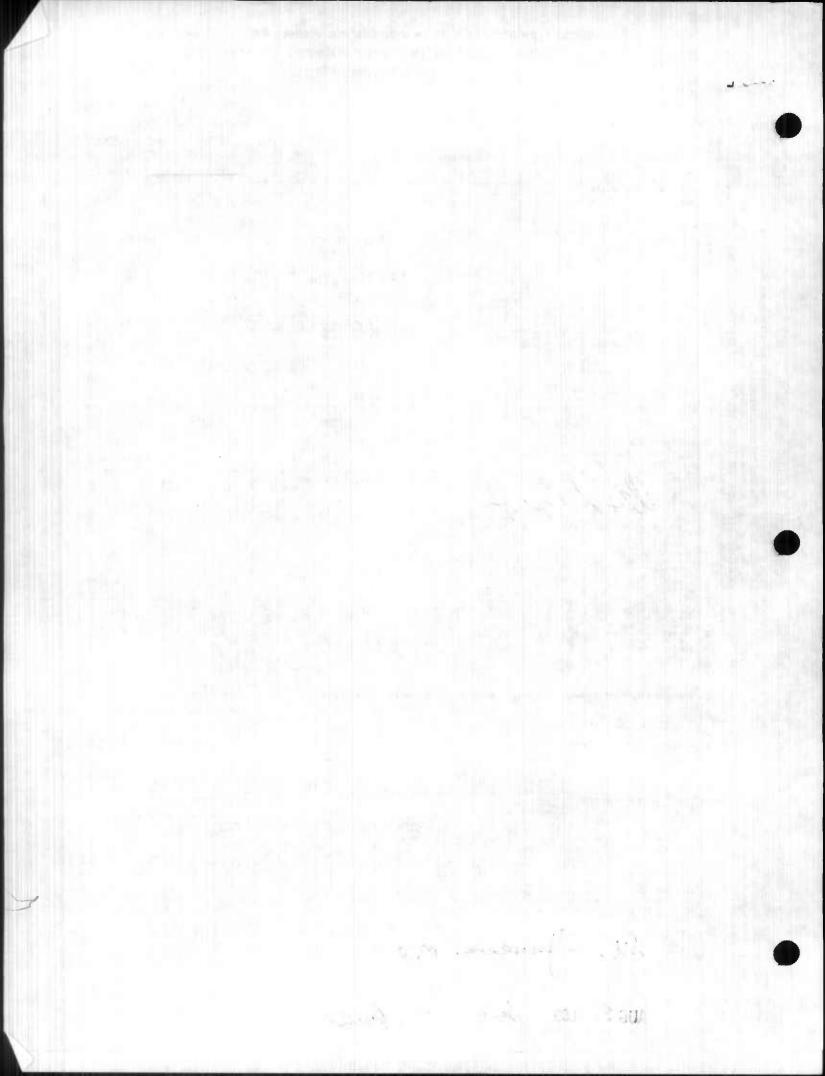
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	State of Maryland / Department	of Health and Mental Hygiene	0
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Amended It	em#8 perFHG787 9/21/2000 EW	Certificat	e of Death	R	eg. No.	29005					
Physician	1. Decedent's Name (First, Middle, Last)			2. Date of Dee Month		3. Tima of Death					
Physician /Medical	MARY ALICE BROWN			AUGUST	17,2000 c	8:27pm					
Examiner	4a Facility Name (If not institution, give street end number)		4b. City, Town, or I	ocation of Death	4c. County of I	Death					
	FORT WASHINGTON HOSPITAL O	CENTER		SHINGTON		GEORGES					
Funeral Director	577-22-7035	(In yrs. last birthdey) If Unde 81 Yrs. Months	r 1 Yeer If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Dey JAN 2	1-9-1919 9. Year) 5,1919	Birthplace (State or Foreig Country) WASHINGTON D					
Pui *	Usual Residence of Decedent  10a, Stete 10b. County	10c. City, Town or Location	wn or Location 10d. Inside City Limi								
aho aho						1 X Yes 2 □ N					
vith the Me or 28s-f a be notified	MD PRINCE GEORGES  10e. Street and Number	FORT WASHINGT			0- 04						
3a or	9017 MILL ST	10f. Zij	20744		Og. Citizen of What UNITED						
72 hours after death with the Menyland natural; or thems 23e or 28e-f show neal Examiner must be notified at steed by Funeral Director		ver in U,S. 13. Was Dece	dent of Hispanic Orlgin? (Scify Cuban, Mexican, Puert 2 No Specify:	pecify Yes or No- o Rican, etc.)	or No- c.)  14. Race - American Indian, Black, White, etc.  Specify: BLACK						
ed within 72 hours ygiene. or then "naturel", rt, the Medical Exu Completed by	15. Decedent's Education	16a. Decedent's Usu	el Occupation	ting	16b. Kind of Busin	ess/Industry					
within 7 ene.	(Specify only highest grade completed)  Elementery/Secondery (0-12)  College (1-4or 5+)	life. DO NOT u	ork done during most of wor se retired)								
d within	12	CUSTODIAL	WORKER		D.C. GOV	T T					
EIFE D	17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Sumeme)								
	ROBERT JOSEPH COOK		SARAI	H PROCTO	2						
	19a. Informant's Name/Relationship (Type, Print)	19b. Meiling Address	s (Street and Number or Ru	ral Route Number	OR  ober, City or Town, State, Zip Code)  TON ,MD 20744  20c. Location - City or Town, State  CLINTON,MD  ERAL HOME  STVILLE,MD 20747						
242 T	RAYMOND BROWN / HUSBAND	9017 MI	LL ST, FORT	WASHINGTO	ON ,MD 20	744					
200 2 2	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, cremetory or other place)  20c. Location - City or Town, cemetery, cremetory or other place)										
当年を言う	21. Signature Americal Service Licenses	22. Name-a	Address of Facility	ODE BUSIES							
Ped	10. 1 Pres ()					207/7					
	23a. Pert1. Enter the disease, or complications that caused the shock, or heert feilure. List only one ceuse on each line										
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e cha	Porti. Other significant conditions contributing to death but	not resulting in the underlying t	ouse given with air i.	1 D Y		□ Probably 4 □ Unkno					
det det	DIABETIES MELLITUS		E1901E4E09	101	as 25110 5						
the taw requires that has been signed by page 2 should be determined by Pl	DECUBITUS ULCERS			24a. Wes a perfor		24b. Were autopsy finding: available prior to completion of ceuse of death?					
The law atta has by page 2 s				1□ Y	es 💥 No	1 ☐ Yas 2 ☐ No					
certificata rector, pa	25. Wes case referred to medical		26 Plans of Da	ath (Check only or							
	examiner?  123 Yes 2 No  Hospital: 1 Inpatient	2 AER/Outpatient 3 D	Other:		ence 6 Other	(Specify)					
rthis and di	27. Manner of Death  28a. Date of Injury  (Month, Dey)		28c. tnjury et Work?	1	ow injury occurred	Specify)					
at Director. After the In by the I uneral Certification:	2 Accident Investigation 3 Suicide 6 Could not be	Year) Injury M y - At home, farm, street, factor	1 Yes 2 No	28f. Location (S	treet and Number	or Rural Route Number,					
d in b	4 Homicide determined 256. Place of Injur- building, etc.	(Specify)		City or Tow							
within 24 hours after To the Funeral Directory filled in by Medical Certi	29a. Certifier (Check only one)  Certifying Physician: To the best of and menner state and menner state	xamination and/or investigation									
To the somp	29b. Signature and title of certific	29	c. License number	2	9d. Dete signed (/	Month, Dey, Year)					
	M. Jernan		0054082	A	AUGUST 22	2,2000					
(10)	30. Name and address of person who obmpleted ceuse of dea		/, Q								
W. CO.	6104 OLD BRANCH AVE, TEMPLE 31. Date filed (Month, Day, Year) 32 Registrar		+0								
State	AUC 3 1 2000	w A									

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene

							Cent	itical	e or	Death			Reg.	No.			
		edent's Name (First, Midd	lle, Last,	)								2. Date of D		Day	Year	3. Tima of Death	
Physicia	Δ	Albert Lee Beck, Sr.										Augus				11:45 a	
/Medic Examin	de For	cility Name (If not institution			umber)	-				4b. City, Tov	wn, or Lo	cation of Dea		4c. County		22.12	
Lamin	19.	-D W1110140	Par	n d						C	1 - 7 -			D 1			
		19-D Hillside Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1									Delt 24 Hrs.	8. Date of B	irth		9. Birtho	eorge's lace (State or Foreign try)	
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Director		Residence of Decedent				30						reb. 1	, 1	942	lowa	1	
E Su	10a. S		/		10c.	City, Towr	or Loca	ition							1	Od. Inside City Limits	
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21215-0020 d within 72 hours at plens. In than 'natural', or the Medical Exami	-	Widowed 4 ☐ Divorce	d	Year or	Dates:										V	Vhite	
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/lan	2 F1	oyd B	eck							Ma	rjor	ie Mil	ller				
and and		nformant's Name/Relation	ship (T)	rpe, Print)		19b	Mailing	Addres	s (Stree			Route Num			State, Zip	Code)	
and 2	Jus	anita L. Bec	k -	Wife		10	J_D	н 1	1eid	le Roa	a c	reenbe	1+	MD	20770		
de Tea		elhod of Disposition	14	WIIC	20t	. Place of	Disposit	tion (Na	me of		u, 6	Date		Location -			
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Se me man	21. Sig	gnature of Funeral Service	Licens	<del>6</del> 6	1		Gas	sch'	s Fu	ineral	Hom	e, P.A					
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/Medical		date Cause (Final		Freta	nsive S		Col	1 0	0000	20					-	4 months	
Examiner		ng in death)		EXLE		o (or as a o				L		-			1	4 monens	
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ivi her d in by	E 40	Homicide deter	mined	28e. Plac	ce of Injury - A ding, etc. (Spe	t home, fa	rm, stree	et, facto	y, office			City or 1	own, S	itano Numi itate)	oer or Hun	al Route Number,	
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Tot	₹ 29b. S	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)															
0	A 100	D46704 August 29, 2000											2000				
(15)	30. Na	30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)															
(12)		ombo Kankond							ente	. 122	1 Me	rcanti	1e	Lane.	Larg	o, MD	
S.	21 00	te filed (Month, Day, Year	)		Registrar's Sig				-1100	-, 122	_ 110			,		,-,-	
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DHMH 16 Rev 6/95

Registrar

James Committee of the 
	State of Maryland / Department of Health and Mo	ental Hygien	e 00	29087
amend item	23a per phys/ G787 9/14/00 yf Certificate of Death  1. Decedent's Name (First, Middle, Last)	Reg. N 2. Date of Death	0.	3. Time of Death
Physician	NEILE MAE BOCON		16 2000	ins
/Medical Examiner	4a Facility Name (If not institution, give street and number)  PENINSULA REGIONAL MEDICAL CENTER  4b. City, Town, or Loc SALISBU	cation of Death 4	c. County of Deeth WICOM	
		8. Date of Birth	9 Rinh	nplace (Stete or Foreign
Funeral Director	216-38-9474 10 M 20 F 58 Yrs. Months Days Hours Min.	Month, Day, Year 7-8-4	Col	MD MD
Pu Maria	Usual Residence of Decedent  10a. State 10b. County 10e. City, Town or Location			10d. Inside City Limits
the Marylar 28a-f show mortilised at rector	MD SomesET PRincess Anne			1⊠Yas 2□No
fiter death with the Mai ritema 23e or 28e-1 e sines must be noutlied funeral Director	10e. Street and Number 11374 Granwland School RD 21853	10g. C	itizen of What Cou	untry?
ier death w Berna 23a Bernand	Hali Cigainos egizi I-c	cify Yes or No-	14. Race - Amer	
N 0 0 9	1 Never Merried 2 Married 1 Yes 2 No	Rican, etc.)	Specify: Specify:	lack
15-0020 172 hours at natural, or	15. Decedent's Education 16e. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of workin	16b.	Kind of Business/I	ndustry
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offled with Hygiens. other than tent, treat		(First, Middle, Meide		13000
V Suld	UNKNOWN	Mae	Baco	
Mary, Mary	19a. Informant's Name/Relationship (Type, Print)  19b. Meiling Address (Street and Number or Rural  Cloria Curtis - Daughter 30 188 DEAL FS land RI			11. 41062
	20a. Method of Disposition 20b. Place of Disposition (Name of		Location - City or	Town, State
Pag ment ant: It ury o	4 Donation 5 Other (Specify)	-27.00	alisbur	y, MD
Bait Permit. Depart Import any in	21. Signature of Funeral Service Licensee		me	
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart taiture. List only one cause on each line.	r respiratory arrest,	ne, MD 3	Approximata Intervel Between
Physician	A /- ASCVP	1		Onset and Death
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60, be executed totan and burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.	A	1	
3760, ste be expected by sticlen he burte.	that initiated events	WI	8	
	resulting in death) Last			
Box 6 death certification of for use as	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23h Did tohace	o use contribute	to the cause of death?
ecords, P.O. Box 68 law requires that the death certific as been signed by the attending ph 2 should be detached for use as a pleted by Physician/Mec	Tarti. Sites againstant contenting to deal out not resulting in the underlying cause given at rart.	1 Yes		obably 4 Unknown
The law requires the law requires the page 2 should be d		24e. Was en aut		Were autopsy findings
ecord as been signated as the signature		performed?		evailable prior to completion of cause of death?
E 2 2 2 5		1 ☐ Yes	20 No	I□Yes 2□No
of Vital IP Physician: The Physician: The cardificate real director, page 1: To Be Co	25. Was case referred to medical exeminer?  1  Yes 2 No	(Check only one)	6 DOthas (Saa	26.1
of Physic terthis c neral dire		28d. Describe how in		ny
Division or Attending after death. Director: After is in by the fune	2 Accident investigation M 1 Yes 2 No	8f. Location (Street	and Number or Br	iral Route Number,
DIV	4 Homicide  determined  determined  determined  28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)	City or Town, Ste		rai rioute resillosi,
Division of To the Hospital or Attending Physician 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, e (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stelled.			
To the comple	29b. Signature and title of certifier 29c. License number	29d. C	ate signed (Month	n, Day, Year)
	Mychall Aphill D52198		6/17/0	$\infty$
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dy. Michael So Fronski Blo A; waside Dy. A206  31. Date filed (Month, Dey, Year)  32. Registrar's Signeture	Saliel	wa md	1170
State		2011200	10/11/0	2/30/
Registrar	JUN 2 7 2000 Deneva G. Soark			

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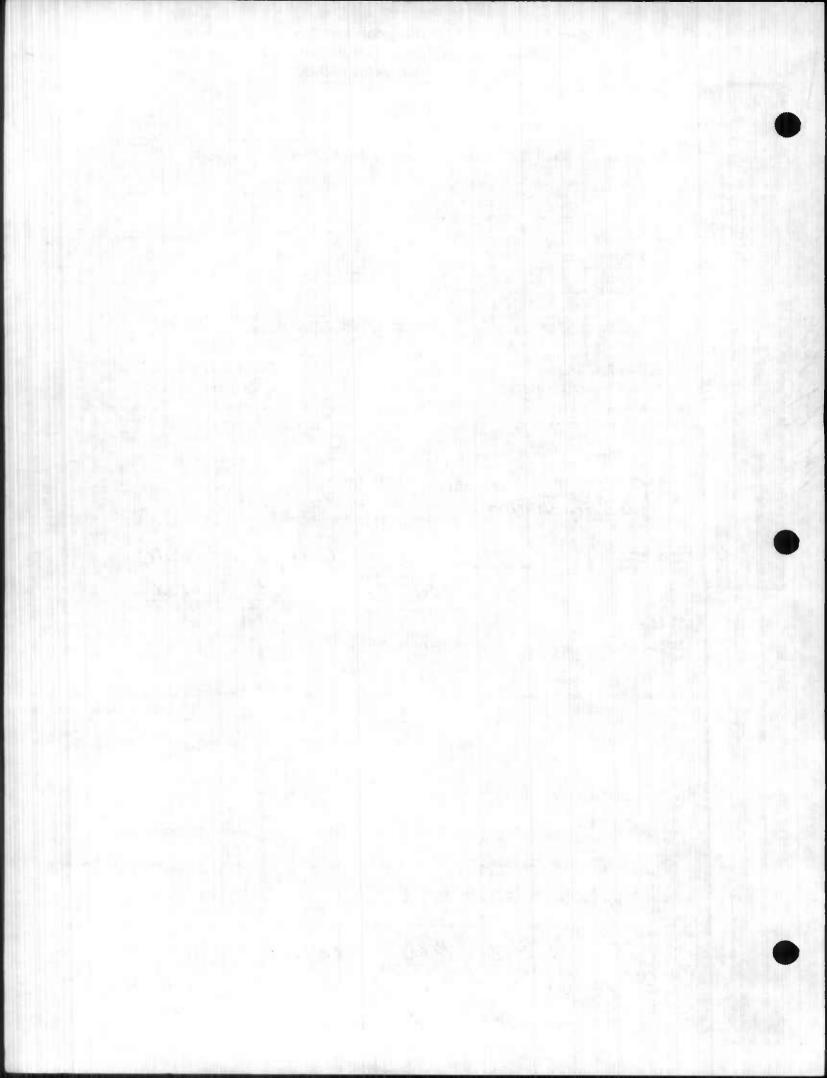
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State of Maryland / Department of Health and Mental Hygiene 00 29088

	Certificate of Death Reg. No.													
Physician .	1. Decedant's Nama (First, Middla, L	2. Data of D Month	eath Day	Yaar	3. Time of Death									
/Medical	GEORGE	EDWA	LD 13	ORN						1436 41				
xäminer	4a Facility Nama (If not institution, gi						or Location of Dea							
	ER FALLSTON						LSTON		LFOR					
	5. Social Security Number 6.	Sex 7. Ag	7. Aga (In yrs. last birthday) II Under 1 Yas			If Under 24 h	fin. 8. Data of B	irth ay, Year)	9. Birthplace Country)					
	217-10-2703	TAR W ZUT	77	rs.			7/1	7/1923	Mar	yland				
	Usual Rasidance of Decedent  10a. Stata 10b. County		10c. City, Town	or Location					104	Inside City Limits				
-		- C 3	100. 04, 101.4	OI EDOUGHOIT		A 3a d as a i	2	W.						
Actions are observed to wary and all the transport of the	MD. Harford Abingdo						ion	)11						
	10e. Street and Number 10f. Zip Coda							10g. Citizen of What Country?						
	124D Waldon Road					21009			U.S.A.					
	11. Marital Status	12. Was Decedent Evar in U,S. Armed Forcas?  1.					' (Specify Yas or Nuarto Rican, atc.)	o- 14. Rac Blac	14. Race - American Indian, Black, Whita, atc.  Specify: Caucasian					
	1 Nevar Married 2 Married							Specifi						
d by	3 ☐ Widowed 4 ☑ Divorced	Yaar or Datas:	MM TT						Cauc	asian				
Bre	15. Decedent's E (Specify only highest gi	Education rade completed)	16a. I	Decedent's Us Giva kind of v	vork dona	eation during most of d)	working	16b. Kind of B	usiness/Indust	try				
Completed	Elementery/Secondary (0-12)	Collega (1-4or 5	5+)	lifa. DO NOT	usa ratired	d)								
S	11		Carpenter						Construction					
Be	17. Fathar's Nema (First, Middla, Las						Nama (First, Middl							
To	George	Edward	Born	emann		Vic	ctorine	DuPo	nt	Butler				
	19a. Informant's Name/Ralationship	(Type, Print)	19b.	Mailing Addre	ss (Street	and Number of	Rural Route Num	ber, City or Town,	State, Zip Co	ide)				
	Sandra L. Born	neman/Dau	ghter	sai	ne a	s #10	a, b, c,	e,f						
	20a. Method of Disposition		20b. Place of	Disposition (A	lama of	ca)	8/23	20c. Location -	City or Town,	, Stata				
	1 Burial 2 Cremation 3 l		Carro				2000	Hamnst	ead.	Maryla				
	21. Signatura of Funaral Sarvice Lice	^	100110	22. Nama	and Addra	ss of Facility								
	mul	11 12	15				son F		Home,	P.A.				
	111. 1200		ng I				Le, Mar							
	23a. Part1. Entar tha disaasa, or cor shock, or heart feilure. List only	mplications that ceused y one ceuse on each li	na maath. Do n	ot antar tha m	oda of dylr	ng, such as cer	diac or raspiretory	arrast,	Int	oproximete terval Between				
n	Onsat and Death													
	Immediata Causa (Final disaasa or condition													
	resulting in death)  Due to (or as a consequence of):													
Ine														
Examiner	Sequentially list conditions, if any, leading to Immediate	0.	Dua to (or es a c	onsequence o	f):	400								
Ē	ceusa. Enter Undarlying Cause (Disaasa or Injury that initiated avents													
edical	that initiated avents rasulting in daeth) Last	G	Dua to (or as a co	onsequence o	f):									
Nec	(894/11/9 11 (4891)   2891													
Bn/M		d												
C	Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I.						23b. DI	23b. Did tobacco use contribute to the cause of death?						
Physician								1 Yee 2 No 3 Probably 4						
by P							_	12 100 22 100 33 100 23						
								24a. Was an autopsy 24b. Wara autopsy findings						
Completed								performed? available prior to completion of ca						
5								of death?						
							1	Yas 2 No	1 U Y	es 200 No				
Be	25. Was cesa refarred to medicel axaminar?	Magnital			100		Death (Check only	ona)						
within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page  Medical Certification: To Be Com	1 Yas 2 No									Homa 5 ☐ Residence 6 ☐ Other (Specify)				
on:	27. Manner of Death  1 ☑Neturat 5 ☐ Pending	28a. Dete of Inju (Month, De		jury	28d. Describe	28d. Describe how injury occurred								
Certification:	2 Accident Invastigation 3 Suicida 6 Could not													
=	4 Homicide datarmine													
Cel														
Ca	29a. Cartifier 1 Certifying P	hyelclan: To the best	of my knowledga,	daath occurre	d at the tir	me, data and pl	lace, and dua to th	e cause(s) end m	anner as state	ed.				
edical	(Check only one)  2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated.													
2										igned (Month, Day, Year)				
	Manuel DAE OCME							AUG	21 2	000				
	30 Name and address of names of	completed acuse of				- 10			1					
	30. Nama and addrass of person who				M	2.7	AIR MI	0 210	14					
	31. Data filed (Month, Day, Year)			mr.	V 1.3	. , , , ,			1					
tate	ALIC O		ar's Signatura	4	1.									

State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death								Reg. No.				
Physician	Decedent's Nama (First, Middle, Last)  GLENN ARTHUR BUTLER								2. Date of De Month	Day	Yaar	3. Time of Death	
/Medical						- 41	Aug				2000	1200	_
Examiner	4a Facility Name (If not institution, give street and number)					41	1107	WM, OF LO		eath 4c. County of Death WICOMICO			
Europal	PENINSULA REGIONAL MEDICAL CENTER  5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Under 1 Ye						If Undar	24 Hrs.	8. Data of Bir (Month, De				7
Funeral Director	n/a	15€M 2□F	0	Yrs.	Months D	ays	Hours 5	Min. 40	August	18,20	I Cou	Maryland	
with the Maryland to co 28s-1 show 1.be notified at	Usual Residence of Decedent  10a. Stata  10b. County		10c. City,	Town or Loc	ation				10d. Inside City Limits				
	Maryland Wicomico Salisbury						1 ⊋ Yas 2 □ No						
	10e. Street and Number 107. Second Street 21801								-	10g. Citizen of What Country?  USA			
nar death v r hems 23a siner must funeral	11. Marital Status 12. Was Decedent Evar in U.S.				13. Was Decedent of Hispanic Orlgin? (Specify					ecify Yas or No- 14. Race - American Indian,			
Eran	1 ☑ Nevar Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	ed 1 Yes 2	Armed Forces? 1 □ Yes 2 3 No If Yes, Give Year or Dates:			If Yes, specify Cuban, Mexican, Puàrto Ri 1 ☐ Yes 2 ☐ No Specify:					ack, White	y: African-American	
ygiene. Ne than 'netur it, the Medical. Completed	15. Decedent (Specify only highes	's Education t grade complated)	ucation 16s de complated)		Sa. Decedent's Usual Occupation (Giva kind of work done during most of wo				ing	16b. Kind of	b. Kind of Business/Industry		
the Mo	Elementary/Secondary (0-12)	College (1-	College (1-4or 5+)  n/a			etirea)				n/a			
O The	17. Fathar's Name (First, Middle,	Last)					18. Mother's Name (First, Middle						
fice even	Walnerque Louis-Jean Mek					Mek	kia Denise Butler						
27 is ma	19a. Informant's Name/Relational Mekia D. Butler								sbury,	er, City or Tow MD 2180		ip Code)	
nt: If then ny or oth	20a. Method of Disposition  1 □ Burial 2 ☑ Cremation  4 □ Donation 5 □ Other (S)		emoval from State 20b. Place of Disposition (Ne cematery, crametory or Salisbury Cre			plece)			Date /21/00	20c. Location - City or Town, State  Salisbury, MD			3
Departe Imports eny inju	22. Nama and Addrass of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804												
o certificate be executed and use as the buriet-transit and use as the buriet-transit and use dical Examiner	Immediate Causa (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Pre	Due to (or a	as a consequence as a c	uence of):	Jr		7/	mo	lhul	,		
requires that the death of the attended by the attend hould be detached for us ated by Physician.								23b. Did tobacco usa contribute to the cause of death?					
d by the attended for us	Part II. Other aignificant conditions contributing to death but not resulting				ng in the underlying couse given in Part I.				1 Yas 2 No 3 Probably 4 Unknown				
cate hes been signed to page 2 should be detected by Possible by P										an autopsy ormed?	a	Vere autopsy findings vailable prior to ompletion of causa f death?	
The law sate hes to page 2 s									10	Yes 2 No	1	☐ Yes 2☐ No	
certificate linector, par o Be Co	25. Was case referred to medical examiner?	Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify)											
2 2 E	1 Yes 2 No	1 Lampatient 2 Li En/Outpatient 3 Li DC				JA 4LI Nuising non				how injury occ		ury)	
Affeir fune fune fune fune	1 Naturat 5 Pending	(Month, Day Year) Injury					Work? 1 □ Yes 2 □ No						
Set in Direct	3 Suicide 6 Could not be determined 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rurel Route Number, City or Town, State)					
Hospi 4 hou Funer taly fill	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
within 2 To the comple	29b. Signature and title of certifier 29c. License number								29d. Data sign	ned (Month	, Day, Year)		
	Martin J. Killy Mil 20034731						8-14-00						
b.	30. Name and address of person; M. J. KEU	who completed ceuse		23a) (Type, I		ST	-	SA	LISBI	1RY	2	1801	
State	31. Data filled (Month, Day, Year)	2000 32. Re	gistrar's Signatu		,					·		4	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** GOLDIE **EDWARD** BURTON HYGUST /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL CAMBRIDGE birthday) H Under 1 Year | H Under 24 Hrs. 8. Date of Birth ORCHESTER GENERAL DORCHESTER 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days MM 20 F Months 218-20-6308 74 Yrs. Director 16 1926 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at Director MD Dorchester 1 ☐ Yes 2 No Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 6356 Suicide Bridge Rd. 21643 U.S.A. "natural", or flams 23s Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 Widowed 4 □ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) maintenance supervisor State of Maryland 11 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be and Mortai is marked John Sullivan Burton Sina Ruark 19e. informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If Item 27 is any injury or other tra once. Health John E. Burton - son 6356 Suicide Bridge Rd., Hurlock MD 21643 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other piace) Date 20c. Location - City or Town, Stete 6 1 Burial 2 □ Cremation 3 □ Removel from State Maryland Veterans Cemetery 9-5-2000 Hurlock MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licansee 22. Name and Address of Fecility Thomas Funeral Home 700 Locust St. Cambridge MD 21613 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset and Death Physician /Medical Immediate Ceuse (Final 12 hours disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medicai Examiner The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or injury that Initiated events resulting In deeth) Last the buriel-tran Due to (or as a consequence of): P.O. Box 68760, Due to (or es a consequence of): the Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ate hes been signed by page 2 should be detac 1 Tyes 2 No 3 Probably 4 Unknown Records. þ Completed 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yea 2 No 1 Yes 2 No Vital certificate Hospital or Attending Physiclan: Be 25. Was case referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Division of After this Certification: 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Netural 5 Pending death. 1 Yes 2 No 2 Accident Investigation efter death filled in by the 3 Sulcide 6 Could not be 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerel C completely filled 29a Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) end manner as stated. Medical 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. \$

29c. License number

29d. Dete aigned (Month, Day, Year)

Cambridge, MD 21613

Registrar

State

29b. Signature and title of cert

31. Dete filed (Month, Day, Yoar) SEP 01

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

408

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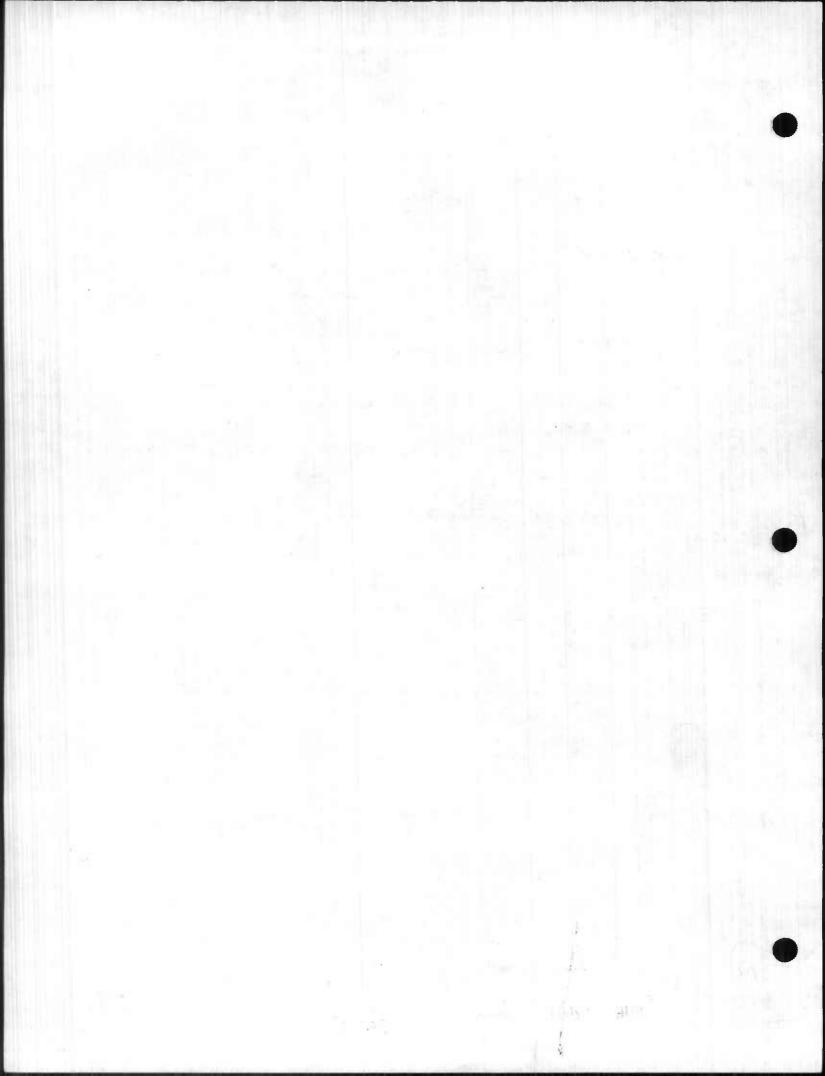
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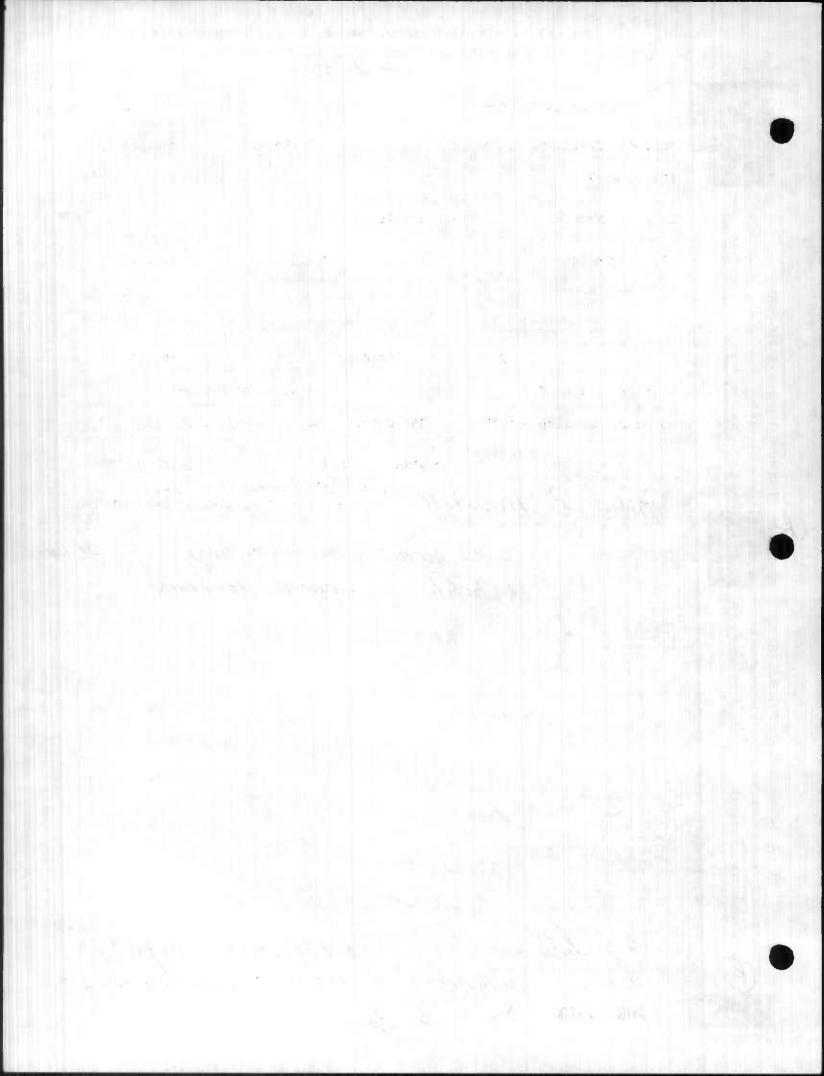
Name (First, Middle, I	State			tificate o			Reg. No.	] 29091			
me (If not institution, g	Last)					2. Dete of De Month	eth Day	3. Time of Death			
	Co	ollins	. Jr.			August	01 00				
	give street and n	ium <i>ber)</i>			4b. City, Town,	or Location of Death		of Death			
6 Clarion	Ct.					shington	Princ	e George			
rity Number 6.	S. Sex	7. Age (In yrs.	. last birthday)	If Under 1 Yes		Irs. 8. Date of Bir (Month, Da	th v. Year)	Birthplace (State or Foreign Country)			
4 9943	1 M 2 F	76	Yrs.	MOTITIS Day	75 THOUS IN	Aug 20		Connecticut			
nce of Decedent											
10b. County		10c. Ci	ity, Town or Loc					10d. Inside City Limits			
P.G.	•		Fort	Washing	gton			1 ☐ Yes 2 No			
d Number				10f. Zip Code	9		10g. Citizen of V	Vhet Country?			
06 Clarion	Court		20744				United	States			
itus	7	ecedent Ever in U	J,S. 13. W	les Decedent o		(Specify Yes or No	- 14. Raci	e - American Indian, ck, White, etc.			
Married 2 Married	d 1 XYes	2 No				Jerto Piloani, etc.)					
ved 4 Divorced	If Yes, C Yeer or			☐ Yes 2 Th	lo Specify:		Specify	White			
15. Decedent's		al)	16a. Decede	ent's Usual Occ	cupation ne during most of	wasking	16b. Kind of Bu	usiness/Industry			
(Specify only highest g /Secondary (0-12)		(1-4or 5+)	life. D	O NOT use ret	ired)	WOINING					
, ( ,	1		Admini	strativ	ve		Tele	phone Company			
ame (First, Middle, La	ast)					Name (First, Middle,	Maiden Sumam	(e)			
arry R. Col	llins, S	Sr.			(Unkno	wn)	Sousa				
nt's Name/Relationship	p (Type, Print)		19b. Mailing	Address (Stre	et and Number of	Rural Route Numb	er, City or Town,	State, Zip Code)			
ael Collins	s (SON)		15207	Bicent	tennial (	Court, Cha	antilly,	Virginia 20151			
of Disposition		20b.	Plece of Dispos cemetery, crem	sition (Name of	oloca)	Date	20c. Location -	City or Town, State			
1 2 Decremation 3		m State				2000	01 in how	Mana-lau d			
4 Donation 5 Other (Specify)  Lee Crematory August 25, 2000 Clinton, Ma 21. Signature of Funeral Service Licensee  22. Name and Address of Facility Lee Funeral Home, Inc											
pi runerei service Lic	1										
Alexandira Ferry Road, Clinton, Maryland 20											
nter the disease, or co r heart tailure. List on	omplications that nly one cause on	t caused the dea neach line.	th. Do not ente	or the mode of o	tying, such as car	diac or respiratory a	rrest,	Approximate tnterval Between			
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ause (Final ndition			Augh	and	OF 1 h	e luc	-	MOS			
eath)	a		or as a consequ								
ist conditions,	D	Due to (	or as a consequ	uence of):							
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eath) Last											
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algnificant conditions	e contributing to	death but not re-	sulting in the un	deriving cause	given in Part I	23h Did	tobacco usa co	ntribute to the cause of death?			
		000000000000000000000000000000000000000		outly my dance	give in the case in			3 Probably Sunknown			
							. 52 20 110				
						24a. Was	an autopsy	24b. Were autopsy findings			
						perfo	ormed?	available prior to completion of cause			
							,	of death?			
S. P. T. S.						10	Yes 200 No	1 ☐ Yes 2 ☐ No			
referred to medicat					_	Death (Check only	one)				
			ER/Outpatient	3 DOA	Other: 4 Nursir	ng Home 5 Resi	dence 6 □Oth	er (Specify)			
ZDENO	28a. Dat (Mo	te of Injury onth, Day Year)	28b. Time of Injury	28c. Ir	njury at Work?	28d. Describe	how injury occur	red			
Death No	tion			M 1	Yes 2 No						
Death at 5 Pending investigat	Ad   209, FIB	ce of Injury - At I	nome, farm, stre	et, factory, offic	СӨ	28f. Location (	Street and Numb	per or Rural Route Number,			
Death at 5 Pending investigat de 6 Could not investigat	Duli	ioniy, etc. (Speci	"7/			Oily or 10	, Glato)				
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Death at 5 Pending investigat de 6 Could not determine	29a. Certifier (Check only one)										
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Death at 5 Pending investigat de 6 Could not determine		anner stated.		29c. Lice	29c. License number 29d. Date signed (Mooth,		1				
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Death  at 5   Pending investigat de cide   Could not determine    Description   Could	and ma			7	) $943$		8/2	5/00			
Death  at 5 Pending investigat de 6 Could not determine	and ma	use of death (Ite		Print)	)1943	)	8/2	5/00			
E de de ci	2 Medical E		<ul> <li>Medical Examiner: On the basis of examinand manner stated.</li> </ul>			and manner stated.	and manner stated.	and manner stated.			

		State of Marylar		tificate of			Reg. No.	0 2	9092
Physician /Medical	Decedent's Neme (First, Middle, La  CARRIE	M C	CLARK			2. Dete of D Month 8/23	/2000	Year	3. Time of Death 2:16 AM
Examiner Funeral Director	255-54-5860		last birthday) Yrs.	If Under 1 Year Months Days	LAUREL  If Under 24 Hrs. Hours Min.	8. Dete of B	PG	9. Birthplac	ce (State or Foreig UNTY, SC
ith the Maryland or 28a-f show se notified at Director	Usual Residence of Decedent  10a. Stete 10b. County  MD PC		ty, Town or Loc	eation				10d	l. Inside City Limit
2 44 500	10e. Street and Number  BREAMORE COURT  9344  20723  11. Merital Stetus  12. Wes Decedent Ever in U.S. Armed Forcas?  1 Never Married 2 Merried 3 Widowed 4 Norced  15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondary (0-12)  12 YEARS  16a. Decedent's Usual Occupation (Give kind of work done during most of willing to the property of						10g. Citizen of V	What Country	n
urs after death very or thems 23s Examiner must by Funeral	1 Never Married 2 Merried	Armed Forcas? 1 ☐ Yes 2 X No If Yes, Give				pecify Yes or N o Rican, etc.)	Bled	14. Race - American Indian, Bleck, White, etc. Specify: BLACK	
to within 72 hours after hydrene, or the the Medical Examinate, the Medical Examinate Completed by Fu	(Specify only highest gr. Elementery/Secondary (0-12)	ade completed)  College (1-4or 5+)	(Give I	aind of work done O NOT use retired	during most of wor	g most of working		usiness/Indu:	stry
Wental Hyge rised other affic event, II To Be Co	17. Fether's Neme (First, Middle, Last		IEAC	HER		ne (First, Middle WALLA	EDUCAT: e, Maiden Suman CE		
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it. Pages itment of h reant: if he njury or of	20e. Method of Disposition  1 Purel 2 Cremetion 3 E 4 Donetion 5 Other (Speci	Removel from State FT (y)	Lincol	N°CEPIETE	1	9/2000	BRENTWO	OD, MD	•
Department of the part of the		Lumner, JR				) 12TH	ST NE, D	C 2001	.7
seen signed by the attending physician and imposition and impositi	shock, or heert feilure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. METASTATIC  Due to (c)  CARDIAC	CARCI or es e consequ ARRHYT	HMIA	BREAST				iterval Between baset and Death MONTHS
the bu	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underfying Cause (Disease or Injury that initiated events resulting in death) Last	c. Due to (o	or es a consequ	ience of):					HOURS
igned by the attending post detected for use as by Physician/Me	Part II. Other algorificant conditions of	contributing to death but not res	ulting in the un	derlying cause giv	ren in Pert I.		tobacco use co		
2 2 2						24a. We per	s en eutopsy formed?	availe	autopsy finding able prior to pletion of cause ath?
ertifi sctor	25. Was case referred to medical exeminer?  1  Yes 2  No	Hospitel: 1 Inpatient 2	ER/Outpatient	3□ DOA Oth	26. Place of Declaration	oth (Check only			res 2□ No
	27. Menner of Deeth  1 Neturel 5 Pending 2 Accident Investigation	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur		28d. Describe	sidence 6 Oth how injury occur	red	
within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined		(y)		me, date end place	City or To	(Street and Numb own, State)		
within 24 hours a To the Funeral I completely filled	29b. Signeture emit title of certifier  20 Medicat Example 20 Medicat	on the basis of examina end manner steled.  My completed cause of death (Item	n 23a) (Type, F	29c. Licens D2417	pinion, death occu	rred at the time	29d. Dete signe 8/23/20	and due to the	ne cause(s)
State Registrar	31. Dete filed (Month, Dey, Year) AUG 2 8 2001		eture	Goars		,,	20101		



State of Maryland / Department of Health and Mental Hygiene

					Cer	tificate o	t Death			Reg. No.		
	cedent's Name	(First, Middle, L	ast)						2. Date of De		Year	3. Time of Death
ician	Cath	erine Lo	ouise Cox						August	Day 27	2000	8:12am
dical 4a Fi	acility Name (If	not institution, g	ive street and num	ber)			4b. City, To	wn, or Loc	cation of Deet			0.12011
IIIIIe:							Doub			Manha		
	cial Security Nu		sex of He	Age (In yrs. las	birthday)	If Under 1 Yes	Beth Beth		6. Dete of Bir	Montg		ace (State or Foreign
			1□M 2₽F		Yrs	Months Dey	s Hours	Min.	(Month, Da	iy, Year)		ace (State or Foreign ry)
	09-39-8 Il Residence of			2:	2				July 1	5,1978	Memph:	is, TN
10a. S		10b. County		10c. City, T	own or Lo	cation					10	d. Inside City Limits
To	nn.	McNair	.7	Λdame	svill	0						1√2 Yes 2□No
2			,	Adam	PATTI				1	40 000 41		**
100.	Street and Nun	nber				10f. Zip Code				10g. Citizen of V	vnat Count	iny?
3.5 11. M	55 Harr	is Lane					38310			U.S.A		
11. M	larital Status		12. Was Deced	dent Ever in U,S. ces?	13. V	Vas Decedent of Yes, specify Cu	f Hispanic Orluban, Mexicar	lgin? (Spen, Puerto F	cify Yes or No Rican, etc.)	- 14. Rac Blac	e - America k, White, e	
15	Never Marrie	ed 2 Married	1 Tes	2 ₽ No		□Yes 2□N						
3	□ Widowed	4 Divorced	Year or Da			- · · · · X	о ороси,			Ороску	White	e
	/Seesi	15. Decedent's I	Education rade completed)	1	6a. Deced	lent's Usual Occ kind of work don	upation	t of workin	20	16b. Kind of Bi	usiness/Ind	ustry
Eie	ementary/Secon		College (1-	4or 5+)	life. L	O NOT use reti	ired)	i or works	'9			
		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2 -	+	S	tudent				Schoo	1	
	ather's Name (	First, Middle, Las	it)			CHUCK	18. Mothe	er's Name	(First, Middle	, Maiden Surnan		
Cl	harles	William	Cox				Shar	on Fa	aith Mo	Mullan		
		me/Relationship			19b, Mailin	a Address (Stre				er, City or Town,	State, Zin	Code)
			an - Moth			arris L						
	Method of Disp		- POUL					uallis	Date ,	TN 383		en State
			☐Removel from S	tate com	etery, cren	sition (Name of natory or other p	place)		Date	ZOC. LOCATION -	Oity Of 10V	mii, Glate
		5 ☐ Other (Spec			orial	Garden	s	8	/30/00	Memphis	, TN	
21. S	Signature of Fur	neral Service Lice	ensee			. Name and Add		ty				
	0.0	- R	Un	1.11		Marshal						
23a.	Part Enter th	e disease, or co	mplications that ca	used the death	Do not ente	4217 9t	h Stre	et N.	W. Was	shington	DC 2	0011 Approximate
	shock, or hear	t failure. List onl	mplications that ca y one cause on ea	ch line.			,		, , ,			Approximate Interval Between Onset and Death
Imme	ediate Cause (I	Final	0.	, 1.		1 0 .cla	. 60	1 1000.	/			701
disea	ase or condition		a. Cen	ru ne	rvou	Soyore	n re	PUIOV	nag			36 hours.
				Due to (or as	s a conseq	uenca of);			, 0,		1	
			b. are	tas futil	h	relance	none	2,	10 6.	rain		
Sequent if eny	uentially list con y, leading to im e. Enter Under	nditions,		Due to (or as							1	
	e. Enter Under se (Disease or i	rlying									ì	
that is	initiated events		С.	Due to (or as	a consequ	uence of):						He I I I I
3	g vousil) L											
Caus that is result			d								1	
Part	Other elanific	cant conditions	contributing to dea	th but not require	og in the ur	deriving cause	given in Part	l.	23b Did	tobacco use co	ntribute to	the cause of death?
Part ti	Other eignin	ount conditions	contributing to dec	an our not resulting	an min ni	samying cause	Strong in Earl	••				ably 4 Unknown
			Now.						1	Yee 225No	3 - 100	eury → □ Unknown
									24a W	an autopsy	24b. We	re autopsy findings
									perfe	ormed?	ava	illable prior to
											of d	leath?
									10	Yes 2500	1□	Yes 2□ No
25. W	Vas case referr	ed to medical					26. Place	e of Death	(Check only	one)		
0	xaminer? ☐ Yes 2014		Hospital:	patient 2 ER	t/Outpatien	1 3 DOA	Wher:			idence 6 Oth	er (Specific	d
	lanner of Death		28a. Date o	Injury 28	b. Time of			-		how Injury occur		,
1	Natural	5 Pending	(Month	Day Year)	Injury	28c. In	vork? ☐ Yes 2☐					
_	! ☐ Accident	investigati	he		_		- 41		201 1	(Otro at a - 4 ht - 1		(Davida Maria
	Homicide	determine	d 286. Place	of Injury - At home g, etc. (Specify)	e, farm, str	eet, factory, offic	<b>28</b>	2		(Street and Numb wn, State)	per or Rural	Houte Number,
			hysician: To the t									
	one)	Z Medical EX	and mann		and/or inv	restigation, in m	у ориноп, сев	atri occurre	च्या पान प्राप्तिन,	, cate and placa,	and due to	ure cause(s)
29b.	Signeture and t	title of certifier	01			29c. Lice	nse number			29d. Date signe	d (Month, L	Day, Year)
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	1	720	11/10	- f - d	2-1/-	10/	011	0-1	/	0/2	//	
30, 14	ame and addre		completed cause	of death (Item 23	sa) (Type,		000 Pag	bar 4 1	1 o D41-	Date.	-2-	M4 00000
		ALTERL	J. W1/	X1160		90	OU KUC	VATT	TE PIK	e, betne	sda,	Md 20892
31. D	ate filed (Monti	n, Day, Year) 2 9 2000	22. Re	gistrar's Signatur								
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State of Maryland / Department of Health and Mental Hygiene 0 0 2 9 0 0 1.

						Cert	ificate	of	Death		F	Reg. No.			
			1. Decedent's Nama (First, Middle, Las	()							2. Date of Dea	ith	V. S.	3. Time of Death	1
	Physician	_	Tuestlie M Co	retor							Month	Day 200	Year	8:30 A.1	N.F
	/Medical	_	Lucille M. Ca  4a Facility Name (If not institution, give	erter	)				4b. City, To	wn, or Lo	ocation of Death			10:30 A.1	YL.
1	Examine	١ ا	Mariner Health of						Beth	esda		Mont	comer	~v	
			5. Social Security Number 6. Se		ge (in yrs. last	hirthday)	If Undar 1	1 Yaar			8 Date of Birth	n I		place (State or Fore	ainn
	Funeral	1	10	M 2⊠F		Yrs.		Days		Min.	(Month, Day	r, Year)	Coui	ntry)	
	Director	-	579-42-7338 Usual Residence of Decedent		80		1.				JULY 3	, 1920	NORTE	H CAROLINA	A
2	1	- 1-	10a. State 10b. County		10c. City, T	own or Loca	ation	-	1				1	10d. Inside City Lim	its
land	de p	5												1 Yes 2 1	No
9	or 28a-f a	W	ASHINGTON, DC		Washir	ngton,						10 - 011 (1	10 -10		
i i	2 2	5	10e. Street and Number				10f. Zip (				200	10g. Citizen of V		ntry r	
5-0020 72 hours after death with the Maryland			1272 Delafield Pl	Lace N E			20	001	7			U.S.A	-		
90	r tema 23 document	126	11. Marital Status	12. Was Decedent Armed Forcas	Ever in U.S.	13. W	as Decede Yes, specif	ent of h	Hispanic Or	igin? (Sp	ecify Yes or No- Rican, etc.)		e - Americk, White,	can Indian, atc.	
9	and in		1 Nevar Married AMarried	1 ☐ Yes XX If Yes, Giva Year or Datas:	No		□ Yes X2	_					v:Blac		
ğ 62	48 2		3 ☐ Widowed 4 ☐ Divorced	Year or Datas:			_ 105 Æ	ATIVO	Specify.			Specify	· DIaC	- K	
2 50	2 20 20	2	15. Decedent's Edu	ucation	1	6a. Decede	ent's Usual	Occup	pation	et of work	ing	16b. Kind of Bu	usiness/In	dustry	
	ygiene. Ner than "naturn It, the Medical	2	(Specify only highest grad Elementary/Secondary (0-12)	Collega (1-4or	5+)	life. Do	O NOT usa	a retire	during mos	st Or WORK	""y				
Z127 d within	r than	5	12	Compar (1-40)		Sales	Cler	k			1	WomenC1	othir	ng, Retai	1
<b>₽</b>	other vant.		17. Father's Name (First, Middle, Last)	Barton Feel					18. Moth	er's Nam	e (First, Middle,				
Maryland	th and Mental Hyg 7 Is marked othe traumatic avant, To Re C		Marvin Sam McDo	onald						Ro	xie un	obtainal	ble		
should	marked marked matic s		19a. Informant's Name/Retationship (T			19h Mailing	Addrass	/Street	t and Numb		al Route Numbe			n Code)	
Ma 12s	h and		Linwood L. Carter								shingto				
	Maria 27 Other tr	-	20a. Method of Disposition	/ Husbern		e of Disposi					Date	20c. Location -		own State	
		1	ty⊒(8urial 2 ☐ Cremation 3 ☐ I	Removal from State		etery, cremi	atory or off	her pla	ica)		Date	200. Location -	City of 1	Own, State	
E a	ury cury		4 Donation 5 □ Other (Specify,	)	Ft. I	Lincol	In Cer	met	ery	Augu	st 28,	2000 Br	entwo	ood, MD	
m it.	Department of Important: If It any Injury or one once.		21. Signature of Funeral Service Licens	500		22.	Nama and	Addre	ass of Facili	ity Ft.	Lincol	n Funer	al Ho	ome	
n	SESS			1 /	01/2	340	01 B1	ade	nsbur	g Rd	. Brent	wood, M.	D 207	722	
	-	+	23a Parti Emerina disease in mana	lications that cause	d the death.	Do not enter	r the mode	of dvi	ing such as	cerdiac	or respiratory ar	rest	1	Approximate	
40			23a. Part1. Enter the disease, or composhock, or heart failure. List only o	one cause on each i	ina.			,			,			Intarval Between Onset and Death	
	ysician		In a dieta Cours (Single	1		,	0		1	1					
	Medical caminer		Immediata Causa (Final diseasa or condition resulting in death)	. /	Due of for as	inne	el,	m	lane	Un	1				
			resulting in death)		Due to (or as	s a consequ	vence of):	1	100						
P	- C	<u> </u>	NOTE OF STREET	h				0							
cute	ial-transit Examine		Sequentially list conditions, if any, leading to immediate	0.	Due to (or as	s a consequ	ence of):						1		
O, g	an a		if any, leading to immediate causa. Entar Underlying Cause (Disease or Injury										1		
. Box 68760, death certificate be axecuted	physician and as the burial-transit	2	that initiated events rasulting in death) Last	C	Dua to (or as	a consequ	ence of):						1		
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la W	5 M	2			1						100		of	omplation of ceuse I daath?	
T e	page 2	5									101	res 2 No	1	□ Yas 2□ No	
	certificate rector, pag		25. Was cese refarred to medical						26 Ptac	e of Des	th (Check only o	ne l		-	_
OT VITAL	s certific director,		axaminar?	Hospital:	aD50	10 4-41-4	20.00	Ot	har a	,			(0	24.4	
O A	5 7		27. Manner of Death	1 Inpati		Outpatient b. Time of				ursing He	oma 5 ☐ Rasio	now injury occur		my)	-
E B	eath. or: After the funer	5	1 ☑Naturat 5 ☐ Pending	28a. Date of Inju (Month, Da	ay Year)	Injury	М	Bc. Inju	ork? ]Yas 2.⊑	1No					
DIVISION or Attending	the the	5	2 Accident Investigation 3 Suicide 6 Could not be							1140	OOA Location //	Direct and Alicei	has as Du	ral Route Number,	
N N	rec n by		4 Homicide determined	286. Place of in	ijury - At home (c. <i>(Specify)</i>	, larm, stre	et, factory,	Office			City or Tov	vn, Stata)	Jer or Mur	ar Moute (vulliber,	
1	within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi														
Hospital	uner in hou	5	29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medical Exam	reician: To the best											
2	within 24 hours at To the Funeral I completely filled	3	one) 2 D Medical Exami	and manner si		SPINI ION	arrigation,	tity	Spiritori, uai	00001	. Su printe inite,	Taro and preve,	55 500		
Tot	Toth		29b. Signature and title of certifier	14	-		29c.	Licen	se number			29d. Data signe	d (Month	, Day, Year)	
	0		DYILLT D	7/11/1	William	,	D	035	81		3	August	25,	2000	
	(-)	-	20 Name and address	X IV	doub (ham a	an /Tree C						-			
	(3/	1	30. Name and address of person who o	empleted cause of	oeam (nem 23	e) (type, P	ririt)								
			Elliot R. Goldst				orget	OWN	Rd.	Beth	esda, M	D 20814			
	State Registrar		ALIC 3. 0.2000	32 Hegist	rar's Signature	14	la		,						
	make of the latest and the latest an		11111- 3-11 /10114	1.0	- 1	Cad .	PEAL PRO	46	-						

00-4790-019 State of Maryland / Department of Health and Mental Hygiene

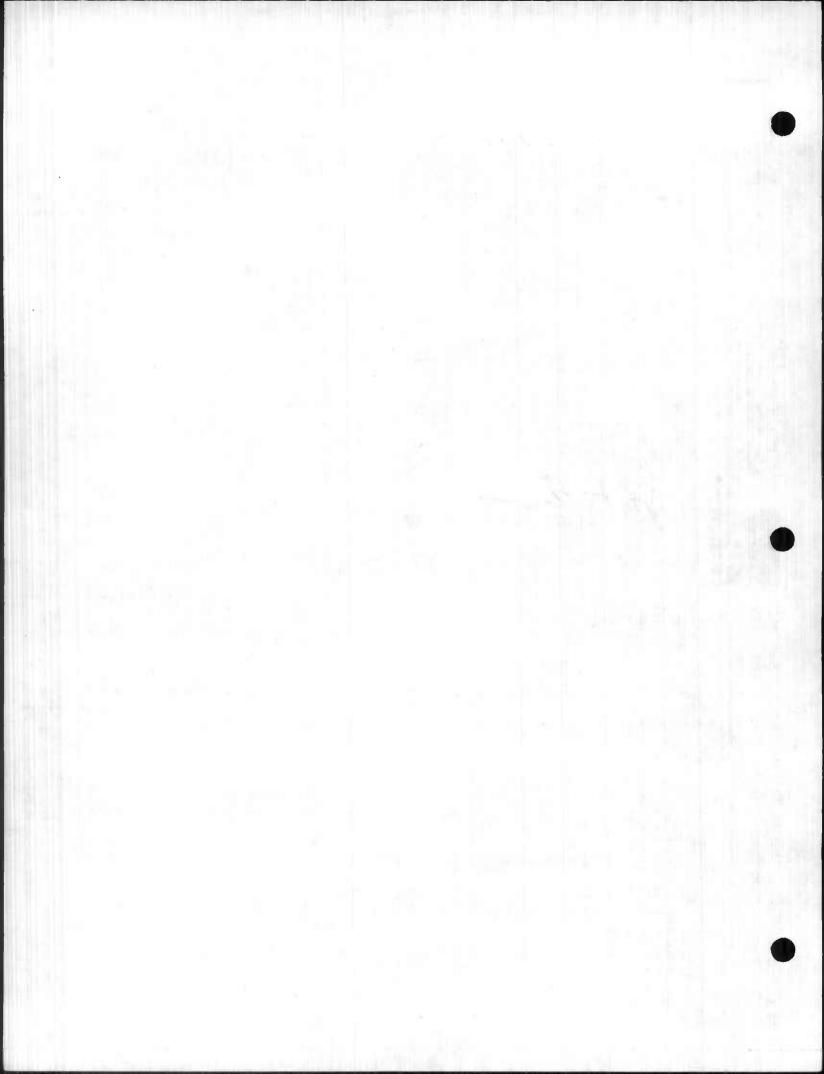
-	asp		Dwand Childs	State of	iviai yiai i		tificate of		ITO IVIETI		Reg. No.	U	29095								
	Dhuaisia		1. Decedent's Name (First, Middle, L	cedent's Name (First, Middle, Last)						ete of Dee	eth Day	Year	3. Time of Death								
-	Physicia /Medica		Dwand							UGUSI	24 2	000	0235								
	Examine	er	4a Facility Name (If not institution, gr DORCHESTER GENE		ber) PITAL			4b. City, Tov CAMBR	vn, or Locatio IDGE	n of Death	4c. County DORCH										
	Funeral Director		5. Social Security Number 6. 578-04-3925	Sex 7	. Age (In yrs. I	last birthday) Yrs.	If Under 1 Yea Months Day		4 Hrs. 8. C Min. A1	ate of Birth Month, Day	, 19 <sup>7</sup> 79	9. Birthpla Countr Washii	ce (State or Foreign								
			Usual Residence of Decedent										0-1								
	Manylan ef ahow	tor	10a. State 10b. County District of Colum	bia		y. Town or Lo shingt						100	d. Inside City Limits								
	h with the	al Direc	10e. Street and Number 1113 Eaton Road	SE			10f. Zip Code	200	)20	U	10g. Citizen of V nited S	Vhet Countr tates	of Americ								
5-0020 72 hours after death with the Manyland netural; or Nems 23s or 28s-f show death and the months of the profits of the states of the stat	ours after deat	To Be Completed by Fur	11. Marital Status  1 X Never Married 2	Armed Ford 1   Yes 2 If Yas, Give	12. Was Decedent Ever in U,S Armed Forces? 1 □ Yes 2 ☑ No If Yas, Give Year or Dates:		<ol> <li>13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> <li>1 ☐ Yes 2 ☒ No Specify:</li> </ol>		in? (Specify Puerto Ricar	Yes or No- n, etc.)	Blac	e - America ek, White, et Black	c.								
21215-0020			15. Decedent's Elementary/Secondary (0-12)	ducetion rade completed) College (1-	4or 5+)	Sales Person 18. Mother's			of working				stry unication								
Maryland 2	d out		17. Father's Name (First, Middle, Las Rabone Stewart	<i>(</i> )					r's Name (Fin		Firm Maiden Sumam	12)									
2	2 should and Men a marke surnatic		19a. Informant's Name/Relationship	(Type Print)		19b Mailir	ng Address (Stre			r. City or Town.	State. Zip C	Code)									
2	and 2 s saith an n 27 is or trau		Deborah L. Childs																		
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If Itam 27 i any injury or other tro page.	-	20a. Method of Disposition  1	tate	1411 Taylor St NW W b. Plece of Disposition (Name of cemetery, crematory or other place) Harmony Memorial			Sep 200	5,	20c. Location -	City or Tow	n, Stete									
Baiti	Baltim permit. Pag Department important: I any injury o		21. Supature of Fiftheral Service Lice				Nama and Add		Rober	t G.M	lason Fu	neral									
	Physician /Medical Examiner		23a Enter tha disease, or con- sk, or heart failure. List only Immediate Cause (Finel disease or condition rasulting in death)		Itead		unies	ying, such as	cardiac or ras	piratory ar	rast,		Approximata ntarval Between Onset and Daath								
Box 68760,	ficate be physicia is the bur	edicai	edicai	edicai	edicai	edicai	edicai	edicai	op	edicai	Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last	c		r es a consec r as a conseq							
P.O. B	by the ache	Lu X	Part II. Other significant conditions	contributing to dea	ith but not rasi	ulting in tha u	ndarlying ceuse	given in Part I.			obacco use co		the cause of death?								
Records,	8 5 5	Completed by								24a. Was perto	an autopsy mad?	svai	e autopsy findings lable prior to epletion of cause eath?								
A.	The lay	E								120	res 2□No	1 00	Yes 2□ No								
of Vital	certificate	9 0	25. Wes case referred to medicel examiner?					26. Place	of Deeth (Ch	eck only o	ne)	`									
5	2 00	0	Yes 2 No	Hospital: 1 In	patient 2	ER/Outpatier	I JOU DOA		rsing Home	5 Resid	tence 6 Oth	ar (Specify)	PATE LINE								
	Attending Ph or death. ector: After th by the funeral	Sation:	27. Manner of Death  1 □ Natural 5 □ Pending  2 M Accident investigation	on 8-24	Injury Day Year) 1-3000	28b. Time of Injury	W	jury et fork? □ Yes 2281	No M	otor	vehicle	(011	ision								
Division	ital or Attendurs after deall rai Director: fled in by the	Cerification:	3 ☐ Sulcide 6 ☐ Could not datermined	building	s, atc. (Specify	et	eet, factory, offic	7-136	Do	rches	ter Cour	nty, 1	Route, Number ly								
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only one)  1☐ Certifying P 2☐ Medical Exa	hysician: To the b miner: On the bas and manne	is of axaminal	wledge, death tion and/or in	occurred at the vastigation, in my	time, date and opinion, daat	d place, and o h occurred at	tha time,	causa(s) and ma date and place,	anner as sta and due to	tha cause(s)								
	vithin To the	100	29b. Signature and title of certifier	1		,	29c. Lice	nse number			29d. Data signe	d (Month, D	ay, Year)								
	->-0	-	Study 9 30. Name and address of person who	Completed cause	acl	23a) (Type,	P.	C.M.E			AUGUST	25,2	000								

State Registrar

111 Penn Street, Baltimore, Maryland 21201

2 300

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Nama (First, Middla, Last) 2. Deta of Death 3. Time of Death Dav Month **Physician** MARY ELIZABETH CHAPMAN 9:05 AM AUGUST 26 2000 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore City Villa St. Michael 4800 Seton Dr If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Days Months Hours 1 M 25 F 79 Yrs. 160-18-6069 Director May 19 1921 Pennsylvania Usual Rasidance of Dacedent the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow X□ Yes 2□ No Maryland none Baltimore City Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 21215-3210 IISA 4800 Seton Drive Nerna 23a Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, atc. 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forcas? filed within 72 hours after Hygiene. Wher then "natural", or Ital 1 Yas 2 No If Yas, Giva Year or Dates: 1 Never Marriad 2 Married Baltimore, Maryland 21215-0020 "natural", or Specify: White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Own Home Home maker 12 traumatic avent. 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 is marked othe any Injury or other traumatic avent also. Be Mary Griffith Frist Robert Frist 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 4248 Rocky Ridge Road Sanford, Florida 32773 Robert Chapman (son) 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Domation 5 ☐ Other (Specify) Metropolitan Crematory 9+2-00 Alexandria, VA 4 Domation 21. Signer of Funaral Service Licansee 22. Nama and Addrass of Facility Eberwein Funeral Services M00173 4433 White Pls. La. White Pls., MD 20695 the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failura. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Causa (Finet RDIOMYOPATHY. disaasa or condition rasulting in death) Examiner Examiner ician and burial-transit Sequentially list conditions, if any, taading to immediata cause. Enter Underlying Cause (Disease or injury that initiated avants rasulting in death) Last Due to (or as a consequence of): the death certificate be exacu Box 68760. physician Physician/Medical 94 Due to (or as a consequence of): 980 P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown signed t Division of Vital Records. þ The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed **page 2** 1 Yes 2 No 1 Yes 2 No certificate or Attending Physician: Be 25. Was casa referred to medical axaminar? 26. Place of Death (Check only one) Hospitat: Other: 4 Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manger of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After Naturat 5 Panding death. 1 TYes 2 □ No invastigation 2 Accidant 24 hours after deal Funeral Director: 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of tnjury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital edical 29a. Cartifiar 🖾 Certifying Phyalcian: To tha best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and titla of certifian 29c. License number 29d. Data signed (Month, Day, Year) leeram sueun 30. Nama and addrass of person who complated causa of death (ttem 23a) (Type, Print) COHOS AVE BALTOMDELINS AKHANI, 1 ASNEEM 7220 31. Date filad (Month, Day, Year) 32. Registrade Signeture State SEP 05 2000 Genera Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 2,2000 JOHN CHAYKA 12:20PM 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Genesis Elder Care La Plata Charles If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number If Under 1 Year Sex M 2□ F Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) Days Yrs. 099-14-0968 77 September 9,1922 New York Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 275 Janet Crt. 20711 USA 12. Was Dacedant Evar in U,S. Agned Forcas? 1 X Yes 2 □ No WW I I If Yes, Give Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 11. Marital Status 1 Nevar Married Married 1 Yes 2 No Specify: White Specify: 3 Widowad 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Carpenter (Union) Building 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Anthony Chayka Elizabeth Zolodek Chavka 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edith Chayka/Wife 275 Janet Crt. Lothian, MD 20711 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 9/7/00 Cheltenham, MD Funeral Service Licenses 22. AREHART-ECHOLS FUNERAL HOME, P.A. M00945 P.O. BOX 567 LA PLATA, MD 20646 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Onset and Death EUICEMIA. Immediate Ceuse (Final diseese or condition resulting In deeth) ACWIM X Due to (or as a consequence ot): Due to (or as a consequence of): Due to (or as a consequence ot): Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part i. 23b. Did tobacco use contribute to the cause of death? Unknown 1 Yee 2 No 3 Probably 24e. Wes an autopsy performed? 24b. Wera autopsy findings available prior to complation of causa of death? 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 28. Place of Deeth (Check only one)

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Certification:

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**Physician** 

· /Medical

Examiner

Director

Funeral

py

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**Funeral** 

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow emphylary or other traumatic avent, the Medical Examples must be notified at once.

nore, Maryland 21215-0020

vision of Vital Records, P.O. Box 68760,

Exami Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury intal Initiated events resulting in death) Lest **burlas**physician: s the burla edical 2 Physician/M 987 ģ 2 Completed

Other: Sursing Home 5 Residence 6 Other (Specify)

	1 Yes	Na
27.	Menner of Death	€ □ Dandian

28e. Date of Injury (Month, Dey Year) Pending Investigation

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

9u.	Certifier
	(Check only
	one)

∠ ☐ Accident

3 Suicide

4 ☐ Homleide

critifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and manner as stated.

In dical Examiner: On the best of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

6 Could not be determined

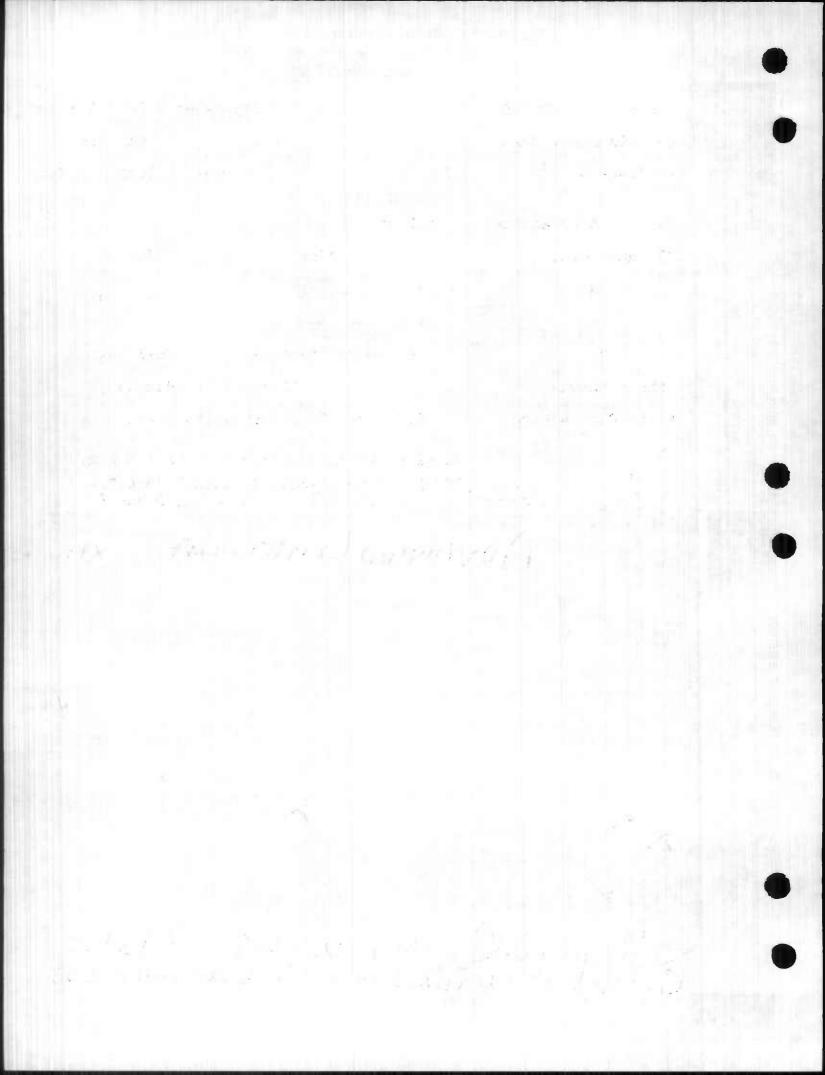
29c. Licansa number

29d. Data signed (Month, Day, Year)

rson who completed cause of deeth (Item 23e) (Type, Print) WALDING, MOZOGO .m.D. AL HOLON

State Registrar 31. Date filed (Month, Dey, Year) SEP 0 5 2000

32. Registrar's Signeture Reper



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 23a per phys/ G787 9/14/00 vf Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Year **Physician** JUNE 22 2000 Robert Warren Carpenter /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fallston General Hospital Fallston Harford If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 10XM 20 F Director 245-46-9638 66 15, 1934 North Carolina **Usual Residence of Decedent** 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits 1 Yas 20 No Directo 28a-f Maryland Harford Edgewood 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 8 238 2009 Armstrong St. 21040 USA 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1955-60 Never Married 2 Married 8 1 Yes 25 No Specify: altimore, Maryland 21215-0020 Specify. à 3 ☐ Widowed 4 ☐ Divorced White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Man Building Maintenance 17 Father's Name (First Middle Last) 18 Mother's Name (First Middle Maiden Surname) Be 2 should be fi Hannie Vinton Carpenter Edna (nmn) Ham Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) If Item 27 Roger Carpenter/ Brother 1706 N. Fountain Green Rd., Bel Air, MD 21015 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 6 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removel from State 6/26/00 tant: 5 Other (Specify) 4 Donation Little Horse Creek, NC Carpenters Family Cemetery 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ACUTE & CHRONIC RESPIRATORY FAILURE **Physician** months /Medical Immediate Cause (Final disease or condition resulting in death) Mears espera Examiner Due to (or as a consequence of): Examiner years CHRONIC OBSTRUCTIVE PULMONARY DISEASE sician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) CACHEXTA years Box 68760 Physician/Medical Due to (or as a consequence of): P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2□ No 3 Probably 4 Unknown signed b Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 2 No certificata of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitaf: 1 Appatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Division After or Attending 5 Pending 1 UNaturat 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident investigation 6 Could not be 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical ş 29b. Signature and title of certifie 29c. License number Date signed (Month, Day, Year)

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ARPENTER

State Registrar Albert S C SUN, MD. 1
31. Date filed (Month, Day, Year)

JUN 2 6 2000

Albert S C SUN, MD. 1
32 Registrar's Signature

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

Win

1716 Harford Road #105 Fallston MD 21047

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month Year **Physician** NORMAN PIERRE CHANAUD, JR. AUGUST 21, 2000 9:10PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VA MARYLAND HEALTH CARE SYSTEM PERRY POINT CECTL 8. Date of Birth (Month, Day, Year) Dec. 11, 1 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1**∑**M 2□ F Yrs 221-20-4445 67 1933 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Harford Maryland Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8 116 Waldon Road, natural, or items 23s 21009 Apt. I USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, atc. after 1√D¥es 2 No If Yes, Give 1 Never Married 25 Merried 21215-0020 1 Tes 2 No Specify: P Specify 3 ☐ Widowed 4 ☐ Divorced Year or Detes: White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 5+ High School Teacher Public Education Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fit Department of Health and Mental H Important: If Nem 27 is marked oth any injury or other traumatic aver other. Be Pages 1 and 2 should be nent of Health and Mental Norman Pierre Chanaud, Sr. Elizabeth (u/k)Curtin 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Johanna W. Chanaud - Wife 116 Waldon Road, Apt. I, Abingdon, MD 21009 Baltimore, 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete Hilltop Service Corp. 8/23/00 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility
McComas Funeral Home, 21. Signeture of Funeral Service Licensee 1317 Cokesbury Rd., Abingdon, MD 21009 23e. Pert<sup>1</sup>. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, of heart fellure. List only one cades on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel SEPSIS disease or condition resulting in deeth) 1 WEEK Examiner Due to (or es a consequence of): Examiner **PNEUMONIA** 1 WEEK physician and the burial-transit be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initialed events resulting in death) Last Dua to (or as a consequence of): DEMENTIA UNKNOWN Physician/Medical Due to (or as a consequence of) 98 DIABETES MELLITUS TYPE II UNKNOWN 980 signed by the a Pert II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Attanding Physician: 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 450 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 27. Manner of Deeth 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Neturel 5 Pending 1 Yes 2 No death. investigetion 2 Accident after deat Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 | Homicide 8 24 hours a Funeral C Hospital 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as stated.

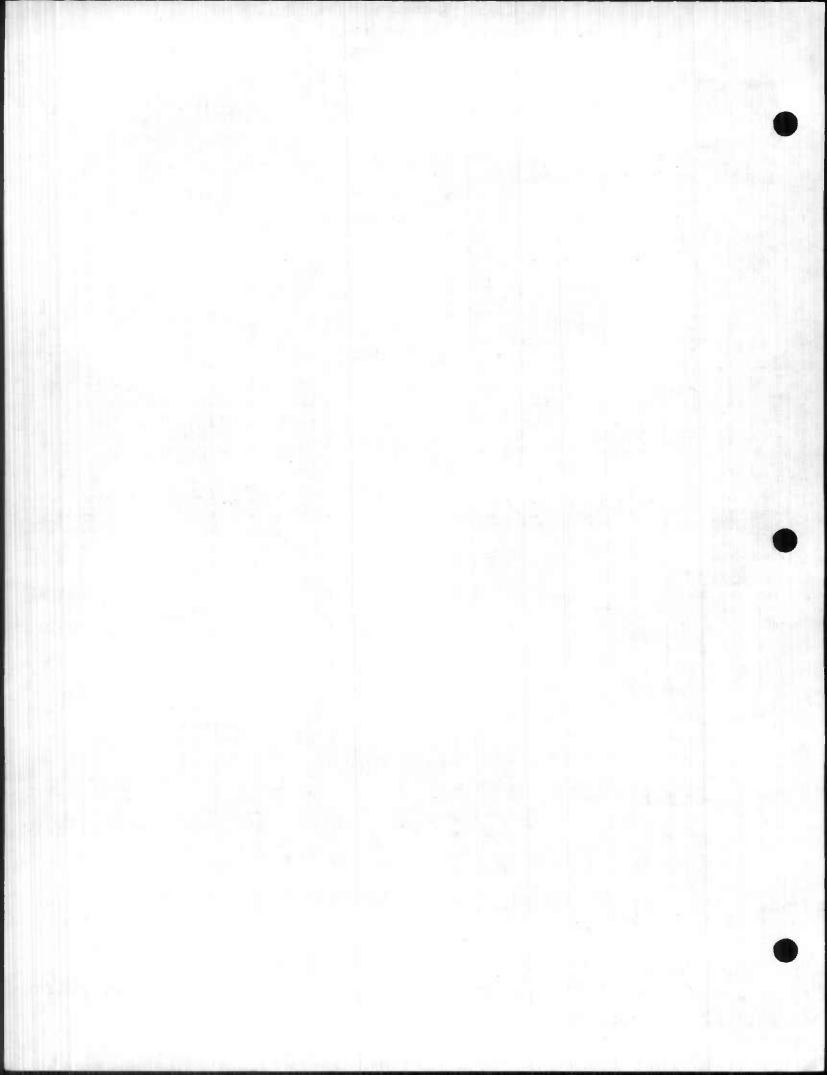
| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted. 29e, Certifier Medical tely (Check only one) within 2 To the \$ 29b. Signatura and titla of curtify 29c, License number 29d. Date signed (Month, Day, Year) M:D 22/2000 D20215 30. Nema and address of person who completed cause of death (frem 23a) (Type, Print) 10+1 KARMACHANDRA NAIR, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

**DHMH 16 Rev 6/95** 

Registrar

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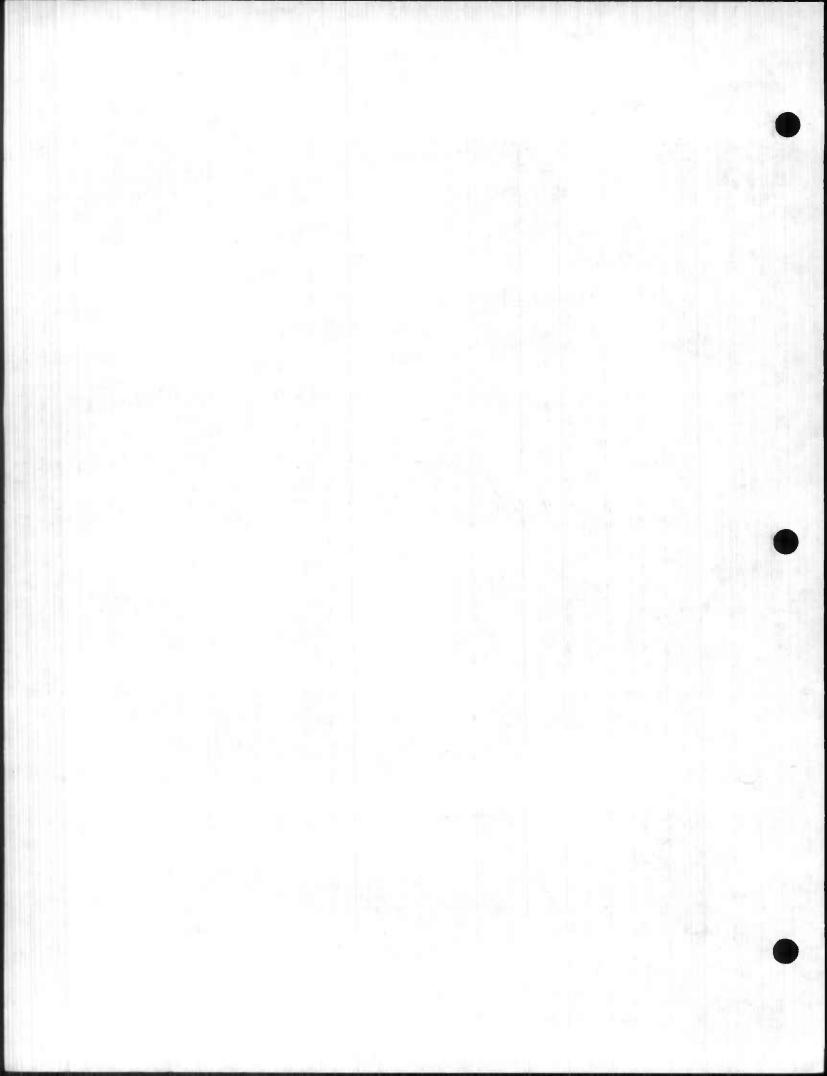
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State of Maryland / Department of Health and Mental Hygiene

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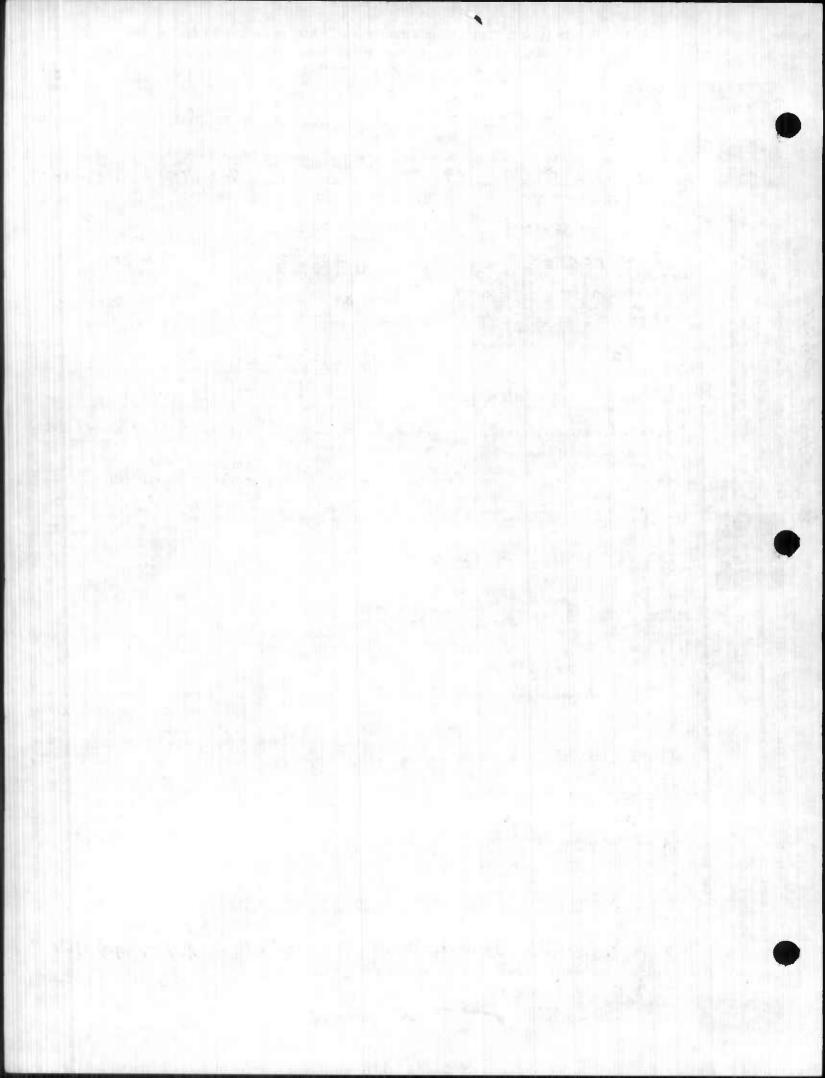
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within 24 hours after death, To the Funeral Director: A completely filled in by the fi		welcles: To the heat of	(knowdodno don)	th accurred at the th	mo data and sta	on and due to the	course(s) and —	0000100	tetod
in 24 hound he Funer pletaly fill		niner: On the basis of exa and manner stated.	mination and/or ir	ivestigation, in my o	opinion, death oc	curred at the time,	, data and place,	and dua to	tha causa(s)
The spin	29b. Signatura and title of certifiar	and manner stated.		29c. Licans	ta number		29d. Data signe	od (Month	Dev Veerl
3 - 8	250. Signatura and title of certifiar	) , 1					A		
	ymuly	Milh	DME	. 0	CME		Avg:	2.2	2000
10		complated cause of death		- A		0			
10	4 PRASHU 72	8 BELANA	10	3 ELAV	LMD	21014	1		
State	31. Data filed (Month, Dey, Year)	32 Registrar's	Signatura	1					
Registrar	AUG 2 4 20	00 Dener	Ø.	DOOK	2/				



State of Maryland

I / Department of Health and Mental Hygie	ene	nn	20	1	0
Certificate of Death	g. No.	00	62		U

				Certificate	e of Death		Reg. No.	0 63101					
		1. Decedent's Neme (First, Middle, Last)				2. Date of Dec		3. Time of Death					
	Physician	GEORGE ED	WARD C	ROPPER		Month	Day st 13, 2	Year 000 2017					
	/Medical Examiner	4a Facility Neme (If not institution, give stri		NOPF CIT	4b. City, Tow	m, or Location of Deeth		.000					
*	LAGITHITE	PENINSULA REGIONAL	L MEDICAL CEN	NTER	SALI	SBURY	WIC	OMICO					
1	Funeral	5. Sociel Security Number 6. Sex	7. Age (In yrs. I	last birthday) If Under			1	Birthplace (State or Foreign Country)					
	Director	221-46-9214 18N	120F 49	Yrs. Months	Deys Hours	Min. (Month, Day	1951	DELAWARE					
_		Usual Residence of Decedent					7707	DEBINA					
	ylan	10a. State 10b. County	10c. City	y, Town or Location				10d. Inside City Limita					
	Man To	MD. CAROL	INE	FEDERAL	SBURB			1 XYas 2 No					
	h the Marylan or 28a-f ahow enotified at	10e. Street and Number		10f. Zip			10g. Citizen of W	hat Country?					
	23a or	302-PORTEI	R COURT		2163=		U	SA					
	iffer death with the Maryland r thems 23a or 28a-f show note must be notified at Funeral Director		. Was Decedent Ever in U.			in? (Specify Yes or No- Puerto Rican, etc.)	14. Race	- American Indian,					
0	T S E	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No			Puerto Hican, etc.)		c, White, etc.					
05	or and	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2	No Specify:		Specify:	BLACK					
5-002	led within 72 ho ygiene. Ner than "natur It, the tendent Completed	15. Decedent's Educat	tion	16e. Decedent's Usual	Occupation	el wedding	16b. Kind of Bu	siness/Industry					
	in a	(Specify only highest grade c Elementery/Secondary (0-12)	College (1-4or 5+)	life. DO NOT us									
2121	d will	12		LINE	WOR	HER	KENT-	SUSSEX IND.					
B	should be filed with Mental Hygiene marked other that immit a vand, the To Be Com	17. Father's Neme (First, Middle, Last)			18. Mother	's Name (First, Middle,	Maiden Sumame	9)					
<u> a</u>	Menta	GEORGE GO	DWIN		De	ROTHY	TRADE	R					
Maryland	and A	19a. Informant's Name/Relationship (Type		19b. Mailing Address		or Rural Route Numbe							
Σ		LYNN CROPDER	/ WIFE	302-PORT	ERCOUR	T. FEDERAL	SBURG	MD, 21632 City or Town, State					
Je.	of He of He r ofth	20a. Method of Disposition	20b. P	laca of Disposition (Namametery, crematory or of	e of her place)	Dete	20c. Location -	City or Town, State					
E	Page ent of T. T. T. O. T. T. T. O. T. T. T. O. T. T. T. O. T. T. T. T. O. T.	1 Surial 2 □ Cremation 3 □ Rem				8/20/200	MILLS	BORD DE					
Baitimore	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr once.	21. Signature of Funeral Servica Licensee	C772	22. Name and	Address of Facility	RENAUE	- Smir	BORD DE.					
ä	Depariment In post	10 80											
		The Part Little the disease or complice	tions that caused the death	P. O. F.	of dving such as o	/, CASIO	N, IVII	), 2/60 2					
	21	Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximately the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Intervedonate the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Intervedonate the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Intervedonate the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Intervedonate the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Intervedonate the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Intervedonate the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Intervedonate the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Intervedonate the disease that the death is a cardiac or respiretory errest.											
	Physician /Medical	Immediate Ceuse (Finel disease or condition Terminal Aspiration 5 h											
	Examiner	disease or condition resulting In death) a					5 hours						
				r as a consequence of):									
	executed in and sal-transit	b	Multiple					1					
_	al-tra	Sequentially list conditions, if any, leeding to immediate	Dysphagia	r as a consequence of):									
68760,	D Die	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events											
687	certificate be nding physicia use as the bu n/Medical	resulting in deeth) Last	Due to (or	r as a consequence of):									
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ă	death of for u					L age Bud	. 6	A 45 14 A 45 A 45 A 45 A 45 A 45 A 45 A					
0	y the check	Part It. Other algnificant conditions contrit	buting to death but not resu	uting in the underlying ca	luse given in Part I.			tributa to the cause of death?					
0	ires that the death certific signed by the attending p d be detached for use as it by Physician/Mee	Cerebral Palsy					faa 2□No	3 Probably 4 Unknown					
Records,	equires					24e. Was	en autopsy	24b. Were autopsy findings					
Ö	been s should	Seizure Disorder				perfo	rmed?	available prior to completion of cause					
36	5 8 W G							of death?					
ē	cata h					101	es 2 No	1 Yes 2 No					
=======================================	Physician: The lave this certificate has ral director, page 2: To Be Comp	25. Was case referred to medical examiner?	spital: 🗸		Other	of Death (Check only o							
To o	2 00 5	1 Yes ZANO	1 Inpatient 2	ER/Outpatient 3 DO		sing Home 5 Resid							
E	ther uner uner lon:	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)		Bc. Injury at Work?		ow injury occurr	90					
Sic	Attending r death. ector: Afte by the fune lfication	2 Accident investigation 3 Suicide 6 Could not be		M	1 Yes 2 N		M	2 12 W N = 1 = 1					
	after death. In Director: After the in by the funers Certification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, factory	, office	City or Tov		er or Rural Route Number,					
	our after death.  The start death.												
	Ne Hospita n 24 hours Ne Funeral pletsky fillie edical C	(Check only 2 Medical Examiner	tan: To the best of my known: On the basis of examinet	wledge, death occurred a tion and/or investigation,	it the time, date end in my opinion, deetl	I place, end due to the obcourred at the time,	euse(s) and ma date end place, a	nner as stated. and due to tha cause(s)					
	4 5 4 5 4 5 4 5 4 5 4 5 5 5 5 5 5 5 5 5	29b. Signature and title of certifier	end menner steted.	200	License number		29d Date sinner	1 (Month, Day, Year)					
	of to	A COLUMN CONTINUE OF CONTINUE	James ( 1 C	wm.D.	D 1529	4	n/Milks	23 21110					
	Teal 1	1 Corner	2.00011114	7 11.12.	V 1250	1	nogosi	10/1000					
	Miles	30. Name and address of person who comp		23a) (Type, Print)	PALLED	ST CA	ISRIB	73,2000 y MD. 21804					
	1	RODNEY A	. WENRIC	H 100	I OWEN :	JI. 97							
	State Registrar	31. Date filed (Month, Day, Year) AUG 24 200	32. Registrar's Signa	G. d.	Day!								



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31. DATE FILED (Month, Day, Year)

AUG 2 8 2000

32. BEGISTRAR'S SIGNATURE

	Page		
	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page		
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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	IRECT	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH AUS 246 YEAR Debra 615 2000 )ante 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR DAYS HOURS 1 M 2 KF 74 227-26-2975 11-05-1925 NEW JERSEY 9e. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR SACRED HEART HOME HYATTSVILLE PRINCE GEORGES 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY DC WASHINGTON 1 XYES 2 NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 919 HAMLIN STREET, 20017 U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuber, Mexican, Puerto Ricen, stc.)
1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES Specify BY Widowed 4 Divorced WHITE 16a. DECEDENT'S USUAL OCCUPATION

16a. DECEDENT'S USUAL OCCUPATION

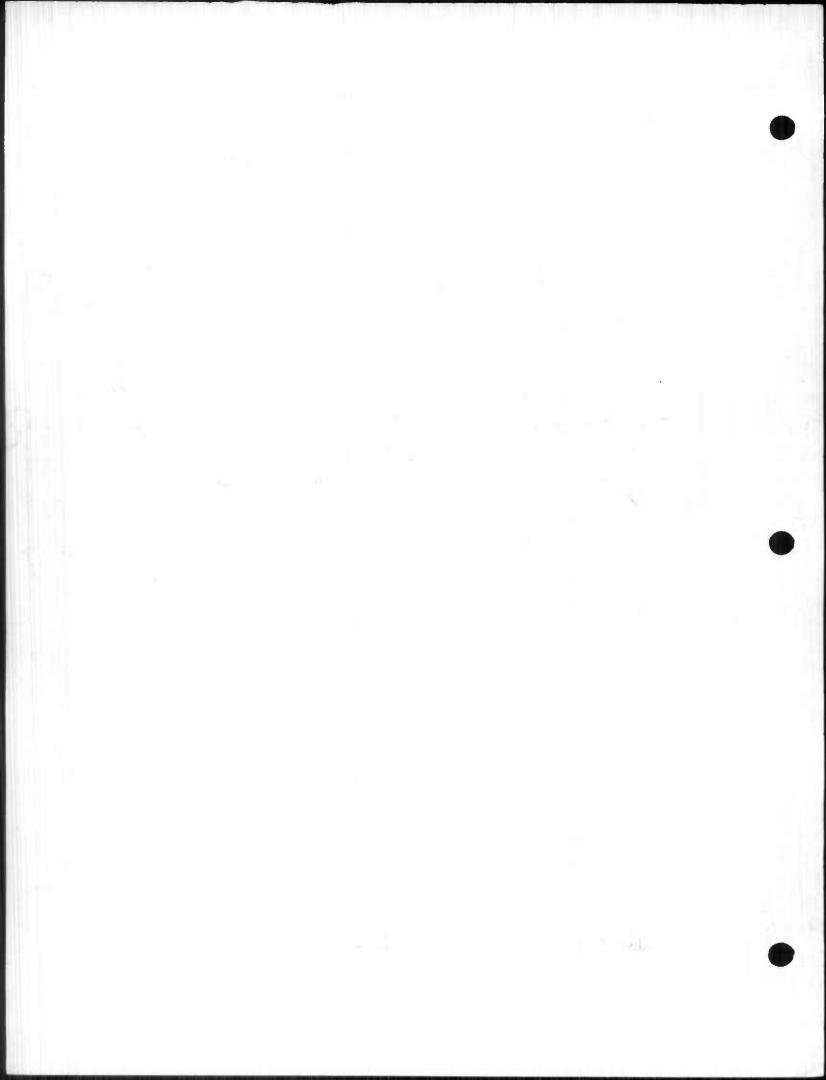
16a. DECEDENT'S USUAL OCCUPATION

16a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16b, KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) COMPLET Elementary/Secondary (0-12) College (1-4 or 5 +) 11th CASHIER N/A 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) CHANCEY REED CATHERINE ZINICKER ш 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) 2 919 HAMLIN ST., NE WASHINGTON, HENRI OUTLAW - SON DC DATE 20c. LOCATION — City or Town, State 28—00 RIVERDALE, 200. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION /Name of 20e. METHOD OF DISPOSITION

1 Burlel 2 Coremation 3 Removal from State

4 Donation 5 Other (Specify) RIVERDALE, MD RIVERDALE PARK CREM 21. SIGNATURE OF FUNGBAL SERVICE LICENSEE 22. NAME AND ADDRESS OF TAYLOR"S FUNERAL 1722 NORTH CAPITOL ST., NW WASH DC 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such ea cardiac or respiratory arrest, shock, or heert fellure. List only one cause on each line. Approximats Interval Setween Onset and Dasth IMMEDIATE CAUSE (Final disesse or condition 5 years Lorcinoma resulting in desth) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO obstructive COMPLETION DE CAUSE 1 TES 2 NO 1 TES 3 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🖾 NO 🗌 UNCERTAIN 🗍 PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA | Shursing Home 5 | Residence 8 | Other (Specify) HOSPITAL: 1 TES 2 10 27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 | Return | 2 | Accident 5 Pending Investigation 1 YES 2 NO BY 28e. PLACE OF INJURY --- At home, farm, street, factory, office building, stc. (Specify) 3 Suicide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Nomicide CERTIFIER (Check only one)

CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner ee stated. DEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29b, SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE ▶ 8/28/00 D37934 52 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stephanie 7500 Greenway Ctr Dive Greenbelt Md 20770 Trifaglio MD



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month. **Physician** Andre C. deCento 9:00 pm AUGUST 28 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** VA MARYLAND HEALTH CARE SUSTEM FERRY ERRY POINT If Under 24 Hrs. 8. Date CECIL 6. Sex 1 → M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 221-07-2521 Yrs. 80 SEPT 8. Delaware Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland 1 Yes 2 No Worcester Snow Hill Director 288-1 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? b 310 Purnelle Drive, Apartment 13 21863 Norms 23a United States 12. Wes Decedent Ever in U.S.
Armed Forces? 1941
1 2 Yes 2 No
H Yes, Give to
Yeer or Dates: 1947 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 ☒ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced 1947 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Landscaper Landscaping Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Albert DiGicinto Nellie Allegretto 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Michael deCento/Son 47 Kollman Drive, Newark, Delaware 19713 mportant: if Item 27 20b. Place of Disposition (Name of 20e. Method of Disposition Date 20c. Location - City or Town, State cemetery, cremetory or other please. Delaware Veterans 1 Burlal 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 9/1/00 Bear, Delaware Cemetery 21. Signature of Fundal St 22. Name and Address of Facility Hicks Home for Funerals, 103 W. Stockton St., Elkton, 21921 ed the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final ARTERU LINKNOWY disease or condition resulting in death) Examiner Examiner 17+IVA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequença of): Physician/Medical Due to (or as a consequence of): Box Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t 1 Yes 2 No 3 Probably 4 Onknown CEREBULAR VASCULAR ACCIDENT Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificate Division of Vital al or Attending Physician: The safer death.

In Director: After this certificated in by the funeral director, ps Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 20 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier 29b. Signature end title of certifie 29c. License number 29d. Date signed (Month, Dev. Year) 8/28/00 D20215 30. Name and address of parts completed cause of death (Item 23a) (Type, Print) VAMARYLAND) HEALTH CARE SYSTEM PERRY POINT, MD KARMACHANDRA NAIR, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 3 1 2000 Registrar

**DHMH 16 Rav 6/95** 

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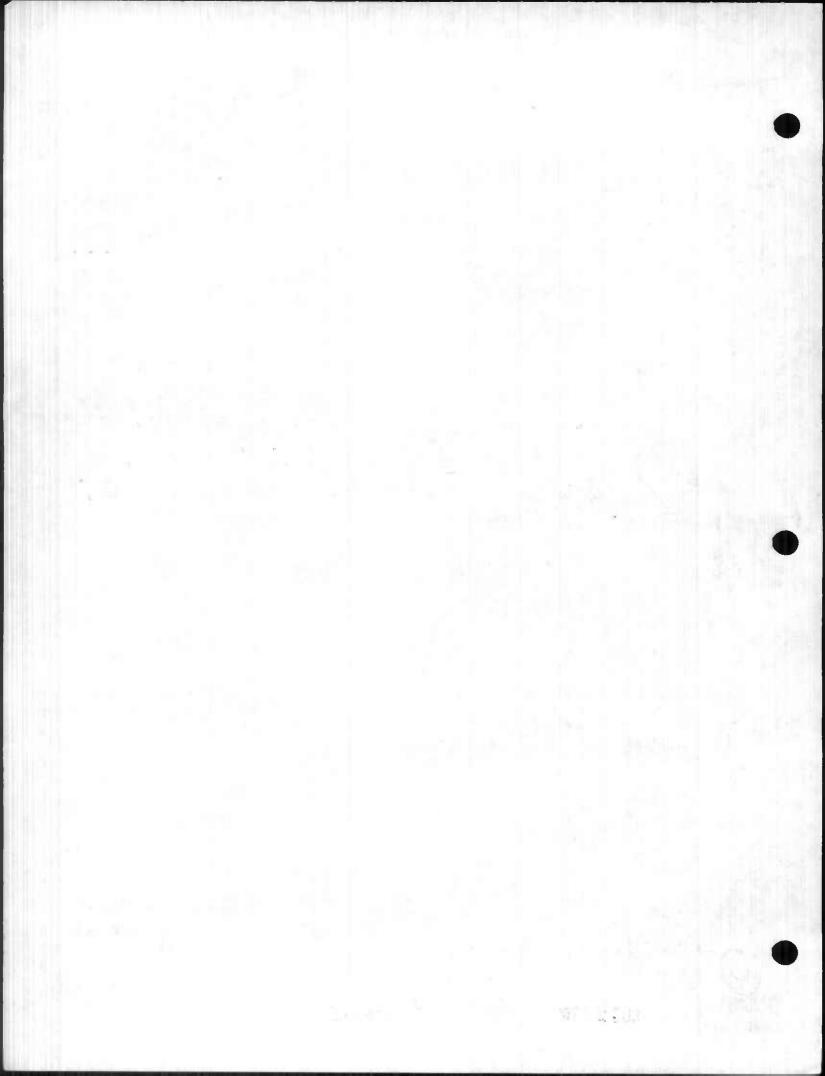
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# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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			Certifi	cate of Death		Reg. No.	20104	
Dhysisian	1. Decedent's Name (First, Middle, Las		1		2. Date of De Month		3. Time of Death	
Physician /Medical	Mary	E. Ecka	ara			25, 200		
Examiner	4a Facility Name (If not institution, give			4b, City, Tow	n, or Location of Deat	h 4c. County o	of Death	
	Washington Adven		1 11 14 1 A B B	Takoma Inder 1 Year   I Under 2	Park	Montg		
Funeral Director	5. Social Security Number 6. S 217-46-6377  Usual Residence of Decedent	ex 7. Age (In yrs. 84		nths Days Hours	Min. 8. Dete of Bit (Month, De	iy, Year) 3,1915	9. Birthplace (State or Foreign Country) Maryland	
ahow ahow	10a. State 10b. County		ty, Town or Location	n			10d. Inside City Limits	
the Mar 28a-f at noutled	Maryland Prince G	1 □ Yas Ž <b>O</b> No						
th with the Maryla 23s or 28s-f ahoust be northed at all Director	10505 Cederville		10g. Citizen of What Country? U.S.A.					
urs after dea lair, or items Exemple in	11. Merital Stetus  1 Never Married 2 Married  3 🛱 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 Yes 2 XNo if Yes, Give Year or Dates;	2 No 1 ☐ Yes 2 No Specify:			(Specify Yes or No- erio Rican, etc.)  14. Raca - American In- Black, White, etc.  Specify: White		
od within 72 hours ygiene. ser than "netural", rt, tre Madical Ex-	15. Decedent's Ed (Specify only highest gra		16a. Decedent's	Usual Occupation of work done during most of	of working	16b. Kind of Business/Industry		
mple mple	Elementary/Secondary (0-12)	College (1-4or 5+)		of work done during most of OT use retired)				
Co Co	8th 17. Fether's Name (First, Middle, Last)	N/A	Cashie		s Name (First, Middle		ail	
d 2 should be file th and Mental Hy 7 la merked oths traumatic avent To Be (		kerall				kerall	,	
should nd Men and Men To	19a. Informant's Name/Relationship (1		19b Mailing Ad	dress (Street and Number			State Zin Code)	
d 2 s lith an trau	Jane Winkler (D	**					Maryland 2060	
permit. Peges 1 end 2 should be filed within Department of Health and Mental Hygiens. Important: If Itam 27 is merked other than any injury or other traumetic avent, the Medes.  To Be Compl.	20a. Method of Disposition	Bemoval from State		(Name of y or other place) Aug			City or Town, State  Maryland	
nit. P	4 Donation 5 Other (Specify 21 Signature of Funeral Sabson Licen			ne and Address of Facility		neral Hon		
permit. Departri Importa any Inju	MADON	6	663	3 Old Alexar	ndria Ferr	y Road Cl	Linton, MD20735	
Physician	23a. Pert1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the deal one cause on each line.	1	^		irrest,	Approximate Interval Between Onset and Deeth	
/Medical Examiner	Immediate Cause (Final disease or condition	· Myocan	rdial 1	ufarction	n		3 weeks	
	resulting in death)	Due to (	or as a consequenc					
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death certificate be executed e attending physician and of for use as the bunial-transit stician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (	Due to (or as a consequenca of):					
ificate be ex g physician and the bunst- ledical Ex	that initiated events resulting in death) Last	C. Due to (c	Due to (or as a consequence of):					
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ath cert for use		0.						
nat the death certified by the attending stached for use a stached for use a Physician/M.	Pert II. Other significant conditions co	ontributing to death but not res	ulting in the underly	ving cause given in Part I.	23b. Dld	tobacco use con	tribute to the cause of death?	
	Hoult respir	covery distre	es syn	doome	10	Yes 2 XNo	3 Probably 4 Unknown	
been shoul	Anoxic enc	ephalo puth	4			s an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?	
certificate has b riector, page 2 s			9		1□	Yes 2500	1 Yes 2 No	
Be C	25. Was case referred to medical			26. Place	of Deeth (Check only		12.00 2900	
Physician: The intrinsical hard inector, page rai director, page:	axaminer? 1 ☐ Yes 2 ② No	Hospital: 1 Anpatient 2	ER/Outpatient 3	Other	sing Home 5 Res		r (Specify)	
£ £ 5	27. Manner of Death					28d. Describe how injury occurred		
or Attending after death. Director: After d in by the fune entification	1 SNatural 5 Pending 2 Accident investigation							
tel or Attending Programmers after death.  al Director: After ted in by the funariation:  Certification:	3 ☐ Suicide 6 ☐ Could not be determined	factory, office  281. Location (Street and Number or Rural Route Number, City or Town, State)						
To the Hospital or Attanding is within 24 hours after death. Completally filled in by the funal Medical Certification.	29a. Certifier Check only one) Control	ysician: To the best of my knowiner: On the basis of examination and menner steted.	owledge, death occurring and/or investig	urred at the time, date and lation, in my opinion, death	placa, and due to the occurred at the time	cause(s) and mar date and placa, s	nner as stated. nd due to the csuse(s)	
Nithin Complete	29b. Signature and title of certifier	\. \		29c. License number		29d. Date signed	(Month, Day, Year)	
	1 Daniets	etros		D3660	1	8/29	12000	
(15)	30. Name and address of person who							
0		4, mb 7600		Ave Takes	ma Park	MD 20	218(	
State	31. Dete filed (Month, Day, Year)	32/Registrar's Signa		la il				



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month Year **Physician** 23rd. Melville Kenneth Elliott 2000 3:00a.m. Aug. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1011 Avery Place Largo, Md. P.G. If Under 24 Hrs. Hours Min. If Under 1 Year 8. Data of Birth (Month, Day Year) 5. Social Security Number 6. Sax 7. Age (In vrs. last birthday) 9. Birthplace (Stata or Foreign **Funeral** Days Months 1**X** M 2□ F APPOMATTOX, VA 87 Director 579-09-9925 Usual Rasidance of Decedant 10b. County/A 10c. City, Town or Location 10d. Inside City Limits 10a Stata 1 Yes 2 No WASHINGTON Director 28a-f 10f. Zip Code 20020 10e. Street and Number 10g. Citizen of What Country? re 23s or 1446 BANGOR ST SE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Wes Decedent Ever in U.S. Armed Forcas? Black, Whita, etc. 1 X Yas 2 (ARMY) Specify: BLACK 1 Never Merried 2 Married 21215-0020 b 1 Yes 2 No Specify: by 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry Hygiene. Elamentery/Secondary (0-12) College (1-4or 5+) SECURITY NONE FEDERAL PROTECTOR OFFICER 12 YEARS Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) es 1 and 2 should be fit of Health and Mental H I ttem 27 is marked off ANNA WRIGHT CHARLES ELLIOTT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
712 NORTHSTONE STREET AVENUE/ROCKVILLE, MD., 20850 19a. Informant's Name/Relationship (Type, Print) DAVID M. ELLIOTT (SON) Baltimore, 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 8/29/00ata 20c. Location - City or Town, Stata Pages nant of h 1 Durial 2 Cramation 3 Ramoval from Steta 4 Donation 5 Othar (Specify) = 510 QUANTICO NATIONAL CEMETERY QUANTICO, VA. 22. Name and Address of Facility 21. Signatura of Funaral Sarvice Licenses mpor mpor any ir John T. Rhines Company Roboto 3030 12th. St., N.E. Wash., D.C. 20017 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsel and Death Physician PROSTATE CANER METASTATIC Immediata Causa (Final disaasa or condition resulting in daath) /Medical HORMONE REFRACTORY Examiner Dua to (or as a consequence of) Examine ician and burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Enter Undarlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of). physician s the buria Box 68760. Physician/Medical Dua to (or as a consequence of): 98 esn. P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yas 2 No 3 Probably 4 Unknown Records, by 24b. Wera autopay findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed' hes page 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Physician: Certification: To Be 25. Was casa ratarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 8 Nother (Specify Relative's Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No this funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After Division or Attending 5 Pending invastigation after death. 1 Yas 2 No 2 Accident the 6 Could not be detarmined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 ☐ Homicide filled in within 24 hours a To the Funeral C completaly filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) \$ 29b. Signatura and titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) labr D50866 10 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print) 50 WEST EDMONSTON DRIVE, ROLLVILLE, MD , SVITE 303 GURDEEP S. CHHABRA

State Registrar 31. Data filed (Month, Day, Year) AUG 2 8 2000 32, Registrar's Signatura

State of Maryland / Department of Health and Mental Hygiene

29106

			Ce	rtificate o	f Death		Reg. No.					
		Decedent's Nama (First, Middle, Last)				2. Data of D Month						
Physicial /Medica	Tessa Fitzmaurice					AUGUS		1635				
Examine	de Canillès Name /// not institution al	va street and number)				own, or Location of De		of Death				
	THE JOHNS HOPKINS	HOSPITAL.			BALTI	MORE CITY	BALT	IMORE				
Funeral	5. Social Security Number 6.	Sex 7. Aga (In y	rs. last birthdey	If Under 1 Ya	r If Under	24 Hrs. 8. Date of E	Birth News	9. Birthplace (State or Foreign				
Director	NONE	1□M 20XF	Yrs.	Months Day	s Hours	AUGUS	T 23, 20	00 MD.				
70	Usual Rasidence of Decedant											
ahow	10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits				
Ma Tal	MD PRINCE	MD PRINCE GEORGES BOWIE										
4 5 A	MD PRINCE  10e. Street and Number	JAC 1877 1		10g. Citizen of \	What Country?							
1020  ours after death with the Maryland  rat, or ferms 23e or 28e-f show  Example: must be notified at  by Funeral Director	12331 TILBURY	LANE		20715			U.S.A.					
de de	11. Marital Status	n U,S. 13.	Was Decedent o	Hispanic Or	igin? (Specify Yes or I		ce - American Indian, ck. Whita, etc.					
O at a f		1 Nevar Married 2 Married 1 Yes 2 No If Yes, Give					Specify					
ours ours	3 □ Widowed 4 □ Divorced	Yaar or Datas:		1□Yes 2XIN	o Specify:		Specin	WHITE				
1215-0020 within 72 hours after ene. then "natural", or the te Medical Exempton	15. Decedent's E (Specify only highast gr Elamentary/Secondary (0-12)	ducation eda complated)	16a. Dece	edent's Usual Occ e kind of work dor	upation e during mos	st of working	16b. Kind of B	usiness/Industry				
2121 3 within gione. r than	Elamentary/Secondary (0-12)	College (1-4or 5+)	College (1-4or 5+)				NONE					
N DOL	0	NONE		1		NONE						
be file dothe avant,	17. Fathar's Nama (First, Middla, Lasi	17. Fathars Nama (First, Miodia, Last)						er's Name (First, Middle, Maiden Sumeme)  A ALEXANDRA MEDWEDEFF				
aryland should be file and Mental Hy a marked oth numatic avant	PETER MICHAEL											
C (4) = 2	19a. Informant's Name/Ralationship					er or Rural Routa Nurr						
C = N L	PETER FITZMAUR		1233		JRY LA		E,MD. 2					
	20a. Method of Disposition  1 🕅 Burial 2 🗆 Cremation 3			osition (Neme of emetory or other p	lece)	8-26-2	000	- City or Town, Stata				
Pa menting	4 ☐ Donation 5 ☐ Other (Speci		ACRED I	HEART C	EMETE		ВО	WIE, MD.				
Baitimore, Jennii. Pages 1 at Department of Hee Important: if ham injury or othe page.	21. Signature of Funeral Service Lice	nsee	2	2. Name and Add	lress of Facili	6512 N.1	W. CRAI	N HWY				
m x z z z z z	KYLE SIMONS	M01206	BI	EALL FU	NERAL		BOWIE, M					
	23a. Part1. Entar the disease, or com shock, or heart failure. List only	plications thet caused the d	eath. Do not en	nter tha moda of d	ying, such as	cardiac or respiratory	arrast,	Approximate Interval Between				
Physician	Shook, or house failule. Else only	one cause on auch mie.						Onset and Daath				
/Medical	Immediate Cause (Final disaasa or condition	Immediate Cause (Final disaasa or condition resulting in death)  Extreme Prematurity  Due to (or as a consequence of):										
Examiner	resulting in death)	8. Due to	o (or as a conse	quance of):	4	1130-64		11110015				
7 5		c. ,						14 hours				
outec ransi	Sequentially list conditions,	Sequentially list conditions.  Due to (or as a consequence of):										
x 68760, erificate be executed ing physician and is as the burial-transit	if sny, leading to immediate											
ficata be e	that initiated events resulting in death) Last	Cause (Disease or injury that initiated events										
o de la constante de la consta	lesoning in death) Last											
		d										
requires that the death or requires that the death or required by the attend hould be detached for us	Part II. Other significant conditions	contributing to death but not	resulting in the	undarlying cause	givan in Part	I. 23b. Di	d tobacco uss co	entributs to the causs of death?				
P.O. at the de disched						1 □ Yss 2 ⋈ No 3 □ Pro						
s the se	Bilateral Grade III Intraventricular Hemorrhage											
cord v require been si should l							as an autopsy rformed?	24b. Ware autopsy findings svailable prior to				
S S S S S S S S S S S S S S S S S S S					-			completion of causa of death?				
The law requir						10	Yes 2 No	1 ☐ Yas 2 ☒ No				
Vital Price The Certificate rector, pag	25. Was case referred to medical				26. Plac	e of Death (Check only						
Of Vital R Physician: The I rhis certificate ha		Hospital: Inpatient	□ FR/Outpatie	ent 3 DOA	Other:			ner (Specify)				
Phys orthis		27. Manner of Death 28a. Data of Injury 28h. Time of 28c. Injury at 28d. Describe how injury occurred										
Olvision of Vital Records, or Attanding Physician: The law requires the after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be death.	1. Natural 5 Pending (Month, Dey Year) Injury Work? 2 Accident invastigation M 1 Yes 2 No											
Attar dea ctor sy the	3 Suicide 6 Could not be datarmined	26a. Place of injury - A	t homa, farm, s	treet, factory, offic	8			ber or Rural Route Number,				
DIVISION ( tal or Attanding P at after death. It Director: After t ied in by the funer	4 Homicide building, etc. (Specify)											
neral fille		nysician: To the best of my i	knowledge, dea	th occurred at the	tima, date ar	nd place, and dua to th	ne causa(s) and m	annar as stated.				
the Hospi thin 24 hou the Funer mpletely fil	(Check only 2 Medical Examone)	miner: On the basis of axam and manner stated.	ination and/or in	nvastigation, in m	oplnion, das	ath occurred at tha tim	a, data and place,	and due to the causa(s)				
Division of the Hospital or Attanding Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Director.	29b. Signature and title of certifier							29d. Date signed (Month, Day, Year)				
	1 Kglowatt	1(Glowath)				Res-000 August 23,						
(2)	30. Nama and address of person who	complated causa of death (	Item 23a) (Type				3-31					
	Karen E. Lewis				rect. 3	Baltimore	MD 2	112.87				
State	Dr. Date filed (Month Day Vees)	32. Registrar's Si		,			1 0					

DHMH 16 Rev 6/95

State

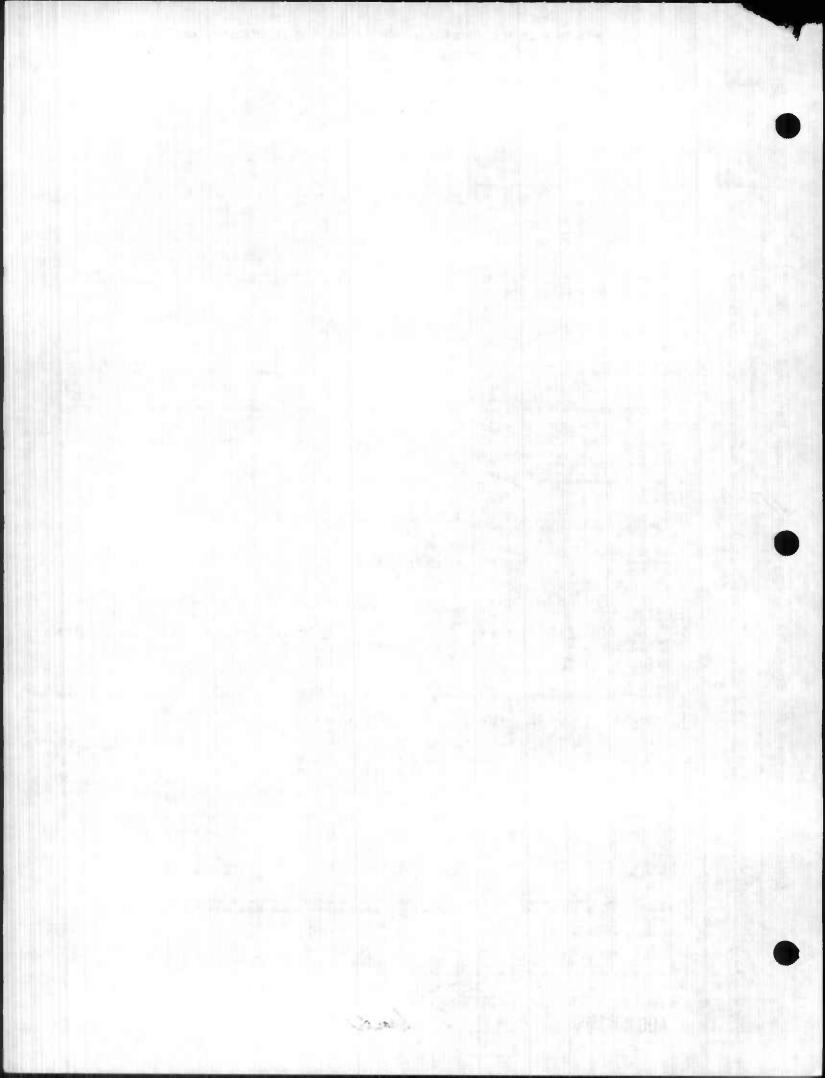
Registrar

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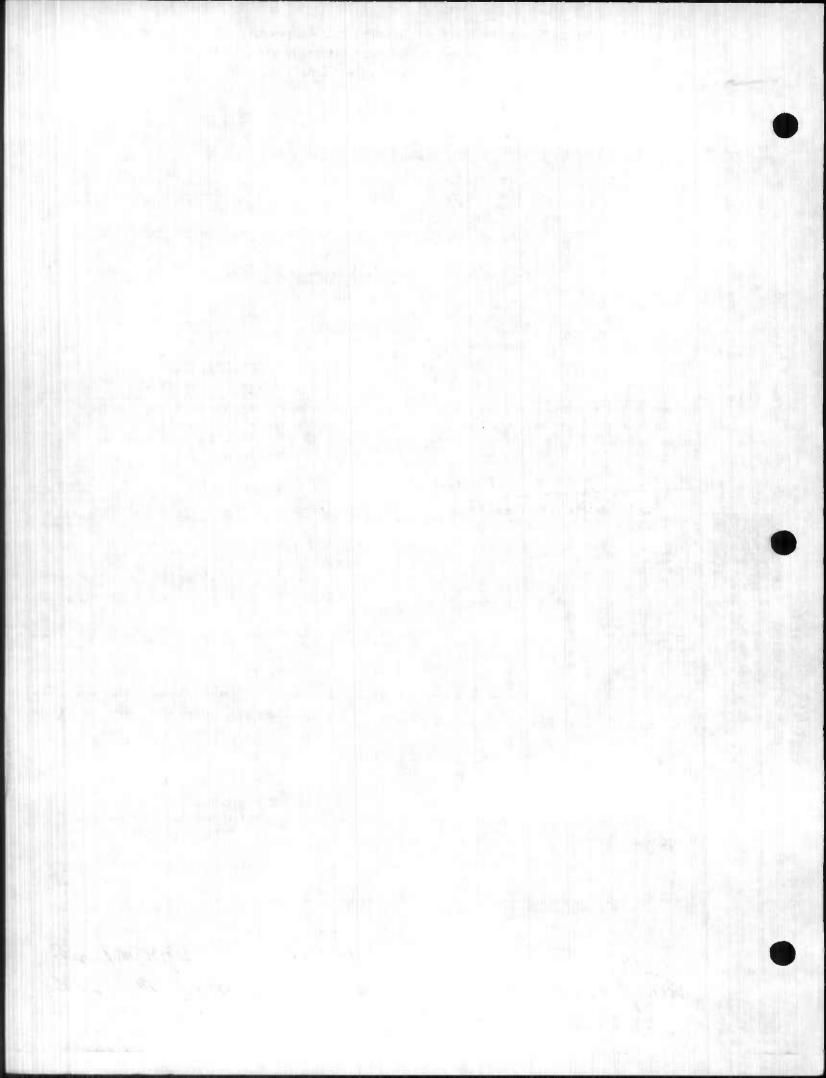
32. Registrar's Signature



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Certificate of	Death	Re	g. No.	
sician	1. Decedent's Name (First, Middle, Last)						Day	Year 3. Time of D
edical	Anna Helion Fl	Lynn		AUGUS	T 30,7	2000 10:0		
miner	4a Facility Name (If not institution	n, give street and number	)		4b. City, Town, or Lo	cation of Death	4c. County o	of Death
1	Doctor's Commu				Lanham			e George's
rat	5. Social Security Number	6. Sex 7. A	ge (In yrs. lest b	Yrs. H Under 1 Year Months Days		8. Dele of Birth (Month, Day,		Birthplace (Stete or I Country)
r	213-38-1958 Usual Residence of Decedent		85	115.		June 19,	1915	Connecticut
	10a. State 10b. County	,	10c. City, Tox	vn or Location				10d. Inside City
be no	N- 1 1 D 1		M. 1 1	. 11			1 ☐ Yes 2	
	Maryland Princ	e George's	Mitch	ellville 101. Zip Code		10	g. Citizen of W	het Country?
	3800 Lottsford	Vista Road	Ever in U.S.	2072			S.A.	- American Indien.
	1 Never Married 2 Man 3 XWidowed 4 Divorced	Armed Forces	?	13. Was Decedent of If Yes, specify Cult		Rican, etc.)	Specify:	, While, elc. Whit
	15. Deceder	nt's Education	166	. Decedent's Usual Occu	pation	1	6b. Kind of Bus	siness/Industry
J	(Specify only highe Elementary/Secondary (0-12)	college (1-4or	E./\	(Give kind of work done life. DO NOT use retin	ed) during most of work	ing		
	—	6+	34)	Teacher		F	G Count	ty Schools
ľ	17. Father's Name (First, Middle,	Last)		4-01 1	18. Molher's Name	e (First, Middle, M	eiden Sumame	9)
	John James Heli	on			Agnes Al	ice Dunc	an	
I	19a. Informant's Name/Relations		19	b. Mailing Address (Stree				Stete, Zip Code)
	John Helion Fly	nn – Son	3	207 Eton Dr	ive. Upper	Marlbon	o, MD	20772
	20a. Method of Disposition		20b. Place	of Disposition (Name of				City or Town, Slate
	1 Surial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Maryl	and Veter	an's	/5/00	helten	ham MD
	21. Signature of Funerel Service		Cemer	22. Name and Addr	ess of Facility		mercem	nam, Fib
		1. I	)	Gasch's F	uneral Hom			
-	23a Part Foter the dispass of	r complications that cause	d the death Do	4739 Balt	imore Aver	ue, Hyat	tsville	e, MD 2078
	23a. Part1. Enter the tiss ase, or shock, or heart failure. List	I only one cause on each	ine.	not onto the mode of dy	mg, soon as caroles	or respiratory arre	31,	Interval Between Onset and De
	Immediate Cause (Final		V Ato					Mar
	disease or condition resulting In death)	a	11/03	mun'a				DOS
			Que to (or as a	consequence of): {				Dim.
		b	D	Leydot	212			(1947)
-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ALC: NOTE:	Due to (or as a	consequende of):				Two 1
	Cause (Disease or Injury that initiated events	с	0.44/	> 0 vone				0002
	resulting in death) Last		Due to (or as a	consequence of):				
		d						
			100000000000000000000000000000000000000			1 001 0144		
h			oul not resulting	in the underlying cause g	iven in Part I.	23b. Did tol	sacco usa con	tributa to the cause of
	Pert II. Other significant condition	ona contributing to death t				4 🖂 14	· allar	2 C Brobobby 4 24
	Pert II. Other significant condition	one contributing to dealing				1 □ Ye	a 2□ No	3 Probably 4 94
	Pert II. Other significant condition	one continuing to death t				1 ☐ Ya 24a. Was an perform	autopsy	24b. Were autopsy fin available prior to completion of ca
	Pert II. Other significant condition	one continuing to death t				24a. Was ar perform	autopsy ed?	24b. Were autopsy fin available prior to completion of ca of death?
					26 Place of Part	24a. Was an perform	autopsy ed?	24b. Were autopsy fin available prior to completion of ca
	25. Was case referred to medica examine?	al .		2 DOA 0	26. Place of Deat	24a. Was ar perform	autopsy ed?	24b. Were autopsy fin available prior to completion of ca of death?
to pe combiered by	25. Was case referred to medica	Hospitel: Inpat	ury 28b.	ulpatient 3LI DOA	ther: 4 Nursing Ho	24a. Was an perform	autopsy ed?	24b. Were autopsy fin available prior to completion of ca of death?  1  Yes 2 N
o be completed by	25. Was case referred to medica examiner?  1   Yes 2   Ro  27. Manner of Death 1   Raturat 5   Pendir	Hospitel: Inpat	ury 28b.	Time of 28c. Injury	ther: 4 Nursing Ho	24a. Was ar perform  1  Ye  h (Check only one	autopsy ed? s 2500	24b. Were autopsy fin available prior to completion of ca of death?  1  Yes 2 N
	25. Was case referred to medica examiner?  1 Yes 2 No  27. Manner of Death 1 Refurat 5 Pendir 2 Accident investi	Hospitel: Inpat 28a. Dale of Inj (Month, Di igation not be	ay Year) 28b.	Time of 28c. Injury M 1[	ther: 4 Nursing Houry at ork?  Yes 2 No	24a. Was ar perform  1 Ye  h (Check only one me 5 Reside) 28d. Describe ho	s 25M6	24b. Were autopsy fin available prior to completion of ca of death?  1  Yes 2 N
to be completed by	25. Was case referred to medica examiner?  1 Yes 2 Ro  27. Manner of Death to Relurat 5 Pendir investi	Hospitel: Inpat  28a. Date of Inj (Month, Di igation not be igned 28e. Place of In	ay Year) 28b.	Time of 28c. Injury	ther: 4 Nursing Houry at ork?  Yes 2 No	24a. Was ar perform  1 Ye  h (Check only one me 5 Reside) 28d. Describe ho	autopsy ed?  s Pono s)  nce 8 Othe w injury occurre	24b. Were autopsy fin available prior to completion of ca of death?  1  Yes 2 N  or (Specify)
Certification: To Be Completed by	25. Was case referred to medica examiner?  1 Yes 2 No  27. Manner of Death 1 Raturat 5 Pendir investi 2 Accident 3 Suicide 6 Could delerm	Hospitel: Inpat  28a. Date of Inj (Month, Di igation not be nined 28e. Place of Ir building, e	ijury - Al home, to. (Specify)	Time of Injury M 1[ arm, street, factory, office	ther: 4 Nursing Ho ury at ork? Yes 2 No	24a. Was ar perform  1  Ye  h (Check only one me 5  Reside 28d. Describe ho  28f. Localion (Str. City or Town.	autopsy ed?  s PINO  n)  nce 8 Othe w injury occurre  eet end Numbe Stele)	24b. Were autopsy fin available prior to completion of ca of death?  1  Yes 2 N or (Specify) ed
Certification: To Be Completed by	25. Was case referred to medica examiner?  1	Hospitel: Inpat  28a. Date of Initial (Month, Discourage)  28a. Place of Initial Individual (Month)  28a. Place of Initial Initial Individual (Month)  28a. Place of Initial I	jury - Al home, to. (Specify)  of my knowledg of examination a	Time of Injury M 28c. Injury M 1[ arm, street, factory, office	ther: 4 Nursing Houry at ork? Yes 2 No	24a. Was ar perform  1  Ye  h (Check only one  5  Reside: 28d. Describe ho  28f. Location (Str. City or Town.	autopsy ed?  s DN6  s DOthe w injury occurred Stete)	24b. Were autopsy fin available prior to completion of ca of death?  1  Yes 2  N  or (Specify) ed
	25. Was case referred to medica examiner?  1   Yes   2   Ro  27. Manner of Death 1   Raturat   5   Pendir investi 2   Accident   3   Suicide   6   Could delerm  29a. Certifier (Check only one)	Hospitel: Inpat  28a. Date of Initial (Month, Dispital)  28a. Place of Initial Duilding, e  28b. Place of Initial Duilding, e  28c. Place of Initial Duilding, e	jury - Al home, to. (Specify)  of my knowledg of examination a	Time of Injury M 28c. Injury M 1[ arm, street, factory, office e, death occurred at the Ind/or investigation, in my	ther: 4 Nursing Houry at ork? Yes 2 No	24a. Was ar perform  1 Ye  h (Check only one me 5 Reside 28d. Describe ho 28f. Location (Sir City or Town and due to the ca	autopsy ed?  s 2500  nce 8 0the winjury occurred state)  eet end Number State)  use(s) and mare te and place, a	24b. Were autopsy fin available prior to completion of ca of death?  1  Yes 2  N  or (Specify) ed
	25. Was case referred to medica examiner?  1 Yes 2 Ro  27. Manner of Death  1 Raturat 5 Pendir investi 2 Accident 3 Suicide 6 Could deferm  29a. Certifier (Check only one)	Hospitel: Inpat  28a. Date of Initial (Month, Dispital)  28a. Place of Initial Duilding, e  28b. Place of Initial Duilding, e  28c. Place of Initial Duilding, e	jury - Al home, to. (Specify)  of my knowledg of examination a	Time of Injury M 28c. Injury M 1[ arm, street, factory, office e, death occurred at the Ind/or investigation, in my	ther: 4 Nursing Houry at ork? Yes 2 No	24a. Was ar perform  1 Ye  h (Check only one me 5 Reside 28d. Describe ho 28f. Location (Sir City or Town and due to the ca	autopsy ed?  s Done  s Dothe w injury occurre eet end Numbe Stete) use(s) and mar te and place, a	24b. Were autopsy fin available prior to completion of ca of death?  1  Yes 2 N  or (Specify)  ed  ar or Rural Route Numb  nner as stated.  Ind due to the cause(s)
fa manadaman and a manadaman and and and and and and and and and a	25. Was case referred to medica examiner?  1   Yes   Yes    27. Manner of Death  1   Raturat   S   Pendir investi    29. Accident   S   Could deferm  29a. Certifier (Check only one)  29b. Signature and title of certifier	Hospitel: Impat  28a. Date of Inj (Month, Di gation not be nined  28e. Place of In building, e  and manner s  or	ury all home, itc. (Specify) of my knowledg of examination a taled.	arm, street, factory, office  e, dealh occurred at the ind/or investigation, in my  29c. Licer	ther: 4 Nursing Houry at ork? Yes 2 No	24a. Was ar perform  1 Ye  h (Check only one me 5 Reside 28d. Describe ho 28f. Location (Sir City or Town and due to the ca	autopsy ed?  s Done  s Dothe w injury occurre eet end Numbe Stete)  use(s) and mar te and place, a	24b. Were autopsy fin available prior to completion of ca of death?  1  Yes 2 N  or (Specify)  ed  ar or Rural Route Numb  nner as stated.  Ind due to the cause(s)
Medical Certification: To Be Completed by Physician/N	25. Was case referred to medica examiner?  1   Yes   2   Ro  27. Manner of Death 1   Raturat   5   Pendir investi 2   Accident   3   Suicide   6   Could delerm  29a. Certifier (Check only one)	Hospitel: Impat  28a. Date of Inj (Month, Di gation not be nined  28e. Place of In building, e  and manner s  or	ury all home, itc. (Specify) of my knowledg of examination a taled.	arm, street, factory, office  e, dealh occurred at the ind/or investigation, in my  29c. Licer	ther: 4 Nursing Houry at ork? Yes 2 No	24a. Was ar perform  1 Ye  h (Check only one me 5 Reside 28d. Describe ho 28f. Location (Sir City or Town and due to the ca	autopsy ed?  s Done  s Dothe w injury occurre eet end Numbe Stete)  use(s) and mar te and place, a	24b. Were autopsy fin available prior to completion of ca of death?  1  Yes 2 N  or (Specify)  ed  ar or Rural Route Numb  nner as stated.  Ind due to the cause(s)

فتسح	Decedent's Name (First, Middle, Last)		Certificate	of Death	Reg	No.	29   08		
Physician /Medical	ELLEN E	ILEEN	FORGET	4b. City, Town, or L	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	29 200			
Examiner	4a Fecility Name (If not institution, give si PENINSULA REGIONA		NTER	SALISBUI		4c. County of Dec			
Funeral Director	210-10-0320	7. Age (In yrs. 75	last birthday) If Under Months Yrs.	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day July 6,1	9. Bi	rthplace (State or Foreign country) and		
laryland show ed at	Usual Residence of Decedent  10a. State 10b. County  Maryland Wicomic		10c. City, Town or Location			10d. Inside City			
or 28a-f sho or 28a-f sho or notified at	Maryland Wicomi	30	Salisbury 10f. Zip 0	Code	100	. Citizen of What C	1 ☐ Yes 2 ☑ No		
death with the Maryland one 23a or 28a-f ahow if must be notified at neral Director	7087 Bethel Church		21804			ountry			
020 urs after death with the Ma at, or items 23a or 28a-f a Examinet must be notified by Funeral Director	11. Merital Stetus 1.  1 Never Merried 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:	,S. 13. Wes Decede If Yes, speci	ent of Hispanic Origin? (Sp fy Cuban, Mexican, Puerto M No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:			
aryland 21215-0020 should be filed within 72 hours after and Mental Hygiene. Instructed other than "natural", or its urradic event, the Medical Examina To Be Completed by Fu	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16a. Decedent's Usuel (Give kind of work life. DO NOT use Housewife	k done during most of work e retired)	cing 16	16b. Kind of Business/Industry  Domestic			
e, Maryland 212 1 and 2 should be filed with Health and Mental Hygiens. am 27 is mericed rother than ther traumatic event, that	17. Father's Neme (First, Middle, Last)			0.0000000		ne (First, Middle, Maiden Surname)			
Maryland of 2 should be file th and Mentel Hy 7 is marked other traumatic event.	Turpin Dunn  19a. Informent's Name/Reletionship (Typ	a Printl	10h Mailing &ddress	(Street and Number or Rul	-	Jarmore	Zin Code)		
and 2 s selth an n 27 ls	Arthur Joseph Forg			hel Church F					
Baltimore, Maryland 212: Department of Health and Mental Hygiene. Important: If item 27 is mented other than any injury or other traumatic event, the H more.  To Be Comp	20a. Method of Disposition  1  Burlal 2  Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State	Place of Disposition (Nem cemetery, crematory or other inghill Memory	her place)		C. Location - City of Hebron, M			
Baltimor permit. Pages Department of Important: If it any Injury or o	21. Signature of Funeral Service Licensee MO(O5)  22. Name and Address of Fecility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804								
S8760, Create be executed physician and sthe buriel-transit sthe buriel-transit sthe buriel-transit sthe buriel-transit state and state	Immediate Cause (Final disease or condition resulting in deeth)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		or as a consequence of): or es e consequenca of):	feed			} 		
A = = =	that initiated events resulting in death) Last	Due to (o	r as a consequence of):						
requires that the death certification signed by the attending thould be deteched for use a seted by Physician/Me	Part II. Other eignificant conditions cont	ributing to death but not res	ulting In the underlying ca	use given in Part I.			te to the cause of death? Probably 4 D Unknown		
	Brews CA	rcen			24e. Wes en performe		. Were eutopsy findings eveilable prior to completion of cause of death?		
The law rate hes b page 2 s					1 ☐ Yes	2 No	1 ☐ Yes 2 ☐ No		
7 2 2 2	25. Was case referred to medical examiner?	ospital: 🚜		Other:	th (Check only one)				
T die	1 Yes 20 No  27. Menner of Death  1 Netural 5 Pending Investigation	28a. Dete of Injury (Month, Day Year)	ER/Outpatient 3 DOA						
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Pleca of Injury - At he building, etc. (Specifical Control of the Control of	ome, farm, street, factory, y)	office	28f. Location (Stre City or Town,		Rural Route Number,		
To the Hoppital Within 24 hours to the Function Completely Illied		clan: To the best of my kno er: On the basis of examina and manner stated.							
To the Howithin 24 To the Forcempletery	29b. Signature end sitle of certifier	29c.	License number	290	29d. Date signed (Month, Day, Year)				
N. I			3	134 768	A	19151 A	9. 2000		
123	30. Name and address of person who con	M.D.	400 E Sh	ore or. s	AUSBUL	1 Ms	2/804		
State Registrar	31. Date filled (Month, Day, Year)	32. Registrar's Signa	14	4					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Physician (Medical Examiner    Sidney M. Goldstein    Month August 22, 2000    9:07al August 22, 2000    9:07al August 22, 2000    9:07al August 22, 2000    4e Facility Name (If not institution, give street end number)    Suburban Hospital    Suburban Hospital    Suburban Hospital    Sociel Security Number    228-30-2756    30M 2 F				Certificate of	Death	R	eg. No,	0 6	2103
Sting May 100 Sting 100 St								Year	3. Time of Death
Substitution in Solution and Management of Earth State (if not institution, give selected and management of the Control of Desired State 1    Solution State 2    Solution State 2    Solution State 2    Solution State 3    Solu		Sidney M.	Goldstein				22, 200		9:07am
Second Second Publisher   Second Second Pu		4e Facility Name (If not institution, given	re street and number)		4b. City, Town, or Loc	cation of Death	4c. County	of Death	
### Social Security Numbers   Security   Sec		Suburban Hospit	a1	OF STATE OF	Bethesda		Mont	gomen	су
28-30-2756  100 Courty 100 Colors	Funeral	5. Sociel Security Number 6. 5	Sex 7. Age (In yrs. la	Months Devs	r If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day,	Year)	9. Birthple Count	ace (State or Foreigny)
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Maryland   Montgomery   Bethesda   100, 2p Code   100, Citizen of What Country?   100, Citiz	3		10c. City.	. Town or Location				10	d. Inside City Limit
Market Satise   1.1   Market Satise   12. Was Decedent Ever in U.S.   13. Was Decedent Flore in U.S.   13. Was Decedent of Hispance Corpor (Speechy Yas on No.   14. Race A American Indian)   11.   Market Satise   11.	or or								Yas 2 N
Married States   1.1   Married States   12. Was Decedent Ever in U.S.   13. Was Decedent of Artispace Color? (Speech) Yas or No.   14. Race. American Indian.   11.   Married States   1.1   Married States	9ct		<u></u> J			1	On Citizen of V	Vhat Count	rv?
Security	Di Di		rrace	101. 21p 0008	20817				•
Security	# 23	11 Marital Status	12 Was Decedent Ever in U.S	13 Was Decedent of	Hispanic Origin? (Spe	cify Yes or No-			
Secure   Comment   Comme	F. T.		Armed Forces?	If Yes, specify Cu	ban, Mexican, Puerto F	Rican, etc.)	Blec		
15. Developing inspect gives completed   16. Developing most of working   16. Rond of Businessatindustry   16. Rond of Businessati	by b		If Yes, Give	1 ☐ Yes 2 🏋 No	Specify:		Specity	: Wh:	ite
Attorney   LAW   Attorney   LAW   Attorney   LAW   Attorney   LAW   Harry Hirsch Coldstein   Rose Hirschfeld   Rose Hi				16a. Decedent's Usual Occu	upation		16b. Kind of Bu	sinass/Inde	ustry
1. Falliar's Name (Prize, Microse, Last)   1. So Notice 's Name (Prize, Microse, Call')   1. So Notice 's Name (Prelatationship (Type, Print)   1. So Name (Prize and Number or Druit Pouts Name (Prelatationship (Type, Print)   1. So Name (Prize and Number or Druit Pouts Name (Prelatationship (Type, Print)   1. So Name (Prize and Number or Druit Pouts Name (Prelatationship (Type, Print)   1. So Name and Soldware (Name and Number or Druit Pouts Name (Prelatationship (Type, Print)   1. So Name and Soldware (Name and Number or Druit Pouts Name (Prelatationship (Type, Print)   1. So Name and Soldware (Name and Number or Druit Pouts Name (Prelatationship (Type, Print)   1. So Name and Soldware (Name and Number or Druit Pouts Name (Prelatationship) (Prize And Name and Name or Committed) (Prize And Name or Commi	Die o					ng	T A T 7		
17. Father's Name Printy, Audoca, Last) 19a. Informer's Name Prelationarity (Type, Print) 19b. Mailing Address (Stever and Number or Prunt Pages Number, Cityer Town, Steve, 250 cde) 19b. Informer's Name Prelationarity (Type, Print) 19b. Mailing Address (Stever and Number or Prunt Pages Number, Cityer Town, Steve 2001.5 19b. Under a Committee or Co	E O	Liemontary/occordary (0-12)		Attorne	ey		LAW		
23a Part Enter the disease, or complicatives that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, inches a flathweat inches a consequence of):    Due to (or as a consequence of):	e at	17. Father's Neme (First, Middle, Last	)		18. Mother's Name	(First, Middle, I	Meiden Sumam	Θ)	
23a. Parti. Enter the dilease, or complicating that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, inches a flathwear contribution or each line.  23a. Parti. Enter the dilease, or complicating that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, inches a flathwear contribution or each line.  23a. Parti. Enter the dilease, or complication or the contribution of cluse on each line.  25a. Due to (or ea a consequence of):  Due to (or as a consequence of):  Part II. Other elignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I.  1   Yes 2   No 3   Probably 4   Unknown of death of de	To E	Harry Hirsch Gol	dstein		Rose H	Hirschfe	eld		
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Coronary Artery Disease   10 year	EES	10 ml. 11 - 1		472 N. Was	shington St	Fall	Ls Churc	ch, V	A 22046
Immediate Cause (Final disease or conditions conditions stuting in death)   Immediate Cause (Final disease or conditions stuting in death)   Immediate Cause (Final disease or conditions stuting in death)   Immediate Cause (Final disease or conditions stuting in death)   Immediate Cause (Final disease or conditions stuting in death)   Immediate Cause (Final disease or conditions stuting in death)   Immediate Cause (Final disease or conditions stuting in death)   Immediate Cause (Final disease or conditions stuting in death)   Immediate Cause (Final disease or conditions stuting in death)   Immediate Cause (Final disease or conditions conditions as a consequence of):    Due to (or as a consequence of):		23a. Part1. Enter the disease, or com	plications that caused the death.	. Do not enter the mode of dy	ying, such as cerdiac o	r respiratory arr	est,	-	Approximate
Immediate Cause (Final disease or conditions resulting in death)   Due to (or as a consequence of):	sician	snock, or neart failure. List only	one cause on each tine.					+	Onset and Death
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Sequentially list conditions or injury leading to immediate cause. Enter Underlying Cause. Enter Under	miner	resulting in death)	a. Due to (or	es a consequence of):					
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Part II. Other elgolificant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other elgolificant conditions contribute to the cause of death of the property of the prop	Pun Lensi	Sequentially list conditions.	b Due to (or	as a consequence of):		100	2 (4)		
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25. Was cese referred to medical examiner?  1	page page					1 Y	as 2 No	1	Yes 2∰ No
27. Manner of Death   28a. Date of Injury   28b. Time of Injury	ctor,				26. Place of Death	(Check only or	10)	-	
27. Manner of Death Y Naturel 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day Year)  28b. Time of Injury M  28c. Injury at Work? 1 Yes 2 No  28d. Describe how injury occurred  28d. Desc	direction of		Hospital: 1 ☐ Inpatient 2 1 1	ER/Outpatient 3□ DOA C	her: 4 Nursing Hor	ne 5 Reside	ence 6 Oth	er (Specify	)
30. Name and address of person who completed clause of death (Item 23a) (Type, Print)  Alan Sheffield, MD 10215 Fernwood Road, Bethesda, Maryland 20817  State 31. Date filed (Month, Dey, Year) 32. Registrer's Signature	nera nera	V_	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Inj	ury at ork?	28d. Describe h	ow injury occur	red	
30. Name and address of person who completed clause of death (Item 23a) (Type, Print)  Alan Sheffield, MD 10215 Fernwood Road, Bethesda, Maryland 20817  State 31. Date filed (Month, Dey, Year) 32. Registrer's Signature	A: A	2 Accident investigation	n	M 1[	☐ Yes 2 ☐ No				
30. Name and address of person who completed clause of death (Item 23a) (Type, Print)  Alan Sheffield, MD 10215 Fernwood Road, Bethesda, Maryland 20817  State 31. Date filed (Month, Dey, Year) 32. Registrer's Signature	recto by t	determined	286. Place of Injury - At not	me, farm, street, factory, office	9			er or Rura	Route Number,
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30. Name and address of person who completed clause of death (Item 23a) (Type, Print)  Alan Sheffield, MD 10215 Fernwood Road, Bethesda, Maryland 20817  State 31. Date filed (Month, Dey, Year) 32. Registrer's Signature	Aed Aed	one)	and manner stated.						
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DHMH 16 Rev 6/95

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### Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Year **Physician** 2000 0824 BERTINA CECILIA HYLTON 4b. City, Town, or Location of Death 22 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hospital MINCE ent & 6 cores Lover If Under 1 Year If Under 24 Hrs. 9. Britispiace (State or Foreign Country) Age (In yrs. last birthday) 8. Oate of Birth (Month, Day, Year) **Funeral** Months Days Hours t□M 20 F April 14,1927 Panama America 73 Director 212-94-2879 Usual Residence of Decedent t Od. Inside City Limits 10a. State 10b. County t Oc. City, Town or Location Maryland Prince George's 1 Yes 2 No Director Largo 25a-f title. Street and Number t Of Zip Code 10g. Citizen of What Country? 23a or must be 386 Harry S. Truman Drive 20772 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 8 1 No Specify: Panamain Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed t6a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) t 5. Decedent's Education (Specify only highest grade completed) t6b. Kind of Business/Industry Hyglens. Elementery/Secondery (0-12) 12th College (1-4or 5+) Homemaker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Byron Nathaniel Padmore Gladys Louise Clayton t9a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Department of Health a Important: If them 27 le any injury or other tra Rupert Hylton/Husband 386 Harry S. Truman Drive, Largo, Maryland 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 08/28 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2000 Clinton, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hear feiture. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Arterioscleratio Cardiovascular Discase disease or condition resulting in death) Examiner Examiner the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pur Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) for use as Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 Yes 2 No 3 Probably 4 → Thicknown þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 1 Yes 2E No t ☐ Yes 2 ☐ No certificata director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2□ No edicai Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No after death 2 Accident in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier t Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Wedical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. completaly (Check only one)

filed within 72 hours after

21215-0020

Baltimore, Maryland

The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

of Vital

Division

Attanding Physician:

8 Hospital

death.

State Registrar 31. Date filed (Month, Day, Year) AUG 2 8 2000

29b. Signature and title of certified

SALVAdan

3001 32. Registrer's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Drive, Cheverly

29d. Date signed (Month, Day, Year)

MARY MAN

### Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien

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	00	60	16

MARVIN JERRY HINES

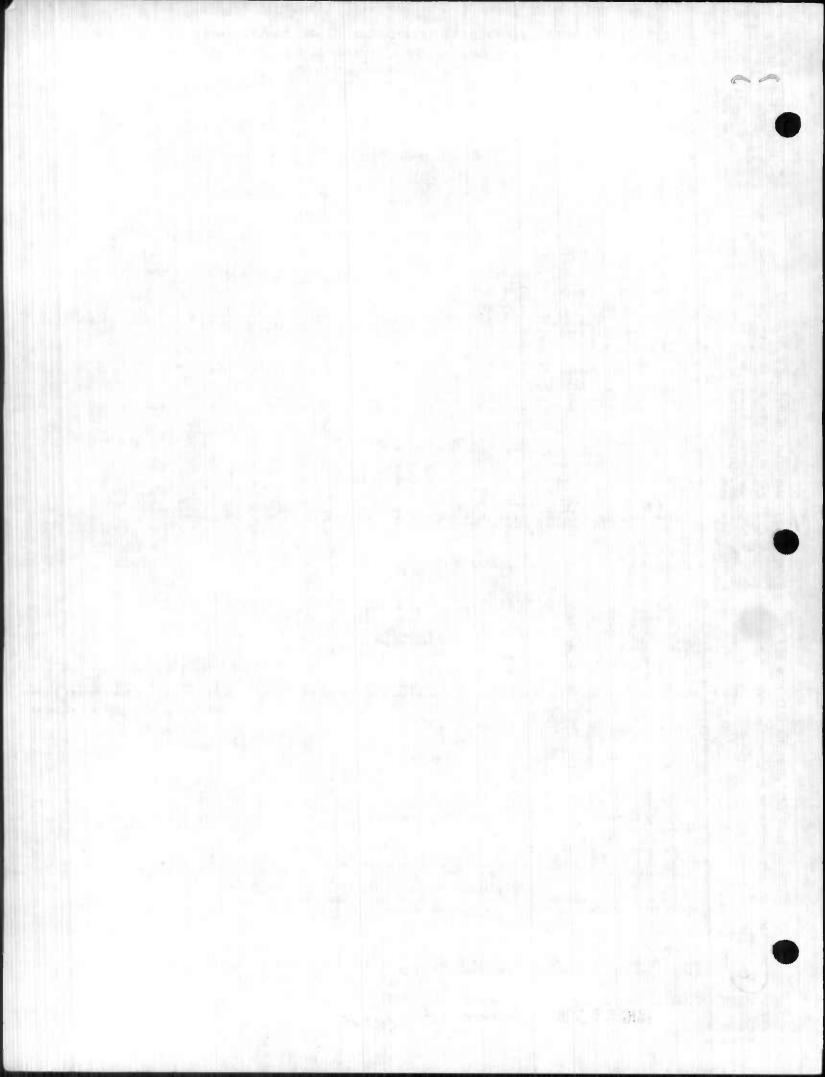
Certificate of Death 1, Decedent's Nama (First, Middla, Last) 3. Tima of Death 2. Data of Death 19,2000 **Physician** Marvin Jerry Hines 10:45 AM AUG. /Medical Facility Nama (If not institution, give street and number) 2908 BRIGHT SEAT ROAD 4b. City, Town, or Location of Death 4c. County of Death Examiner LANDOVER PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1 M 2 □ F Yrs. 246-06-0900 57 North Carolina Dec 16,1942 Director Usual Rasidence of Dacedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Landover 1 Yas 2 No Prince George's Director 10f. Zlp Coda 10g. Citizen of What Country? 10e, Street and Number U.S.A. 20785 2906 Brightseat Rd #201 Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 14. Race - American Indian, Black, Whita, atc. Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 72 hours after 1 Nevar Married 2 Married Black Baltimore, Maryland 21215-0020 1 Yas 2 No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Elementery/Secondary (0-12) Collega (1-4or 5+) Private Floor Specialist permit. Pages 1 and 2 about be file Dopurment of Health and Merial Hyp important: If item 27 is merical Hyp sky injury or other 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middla, Maiden Sumama) Be Bettie Hines James William Hines 19e. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Jacqueline Thomas-Neice Lanham MD 20706 2906 Brightseat Rd 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20e. Method of Disposition Data 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Riverdale Park Crematory 8-24-00 Riverdale, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility J.B. Jenkins Funeral Home 21. Signature of Funerel Sarvice Licensee Non Landover MD 20785 7474 Landover Rd 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failule. List only one cause on each line. Approximate Interval Between Onsat and Daath Physician fmmediata Causa (Final disaasa or condition rasulting in death) /Medical injuries Examiner Dua to (or as a consequence of) Examiner Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaasa or Injury that initiated events rasulting in daeth) Last Dua to (or as a consequance of) The law requires that the death certificate be exec Box 68760. ed by the attending physician detached for use as the burle Physician/Medical Dua to (or as a consequence of) P.O. I Pert II. Other afgnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert f. 23b. Did tobacco use contribute to the cause of death? signed by to 1 Yea 2 No 3 Probably 4 Unknown Division of Vitai Records. by cate has been signated page 2 should b 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed certificate has 1 Yas 2 No 1 Yas 2 No apital or Attending Physician: Thours after death.
Ineral Director: After this certificat
y filled in by the funeral director, pa 25. Was cese refarred to madicel axaminar? Be 26. Placa of Deeth (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 DOther (Specify) AT SCENE Certification: To 1 Yas 2 No 28d. Dascribe how injury occurred Subject was 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? working under cor when fell on his head 5 Pending invastigation 1 Natural 1030 AM 1 Yas 2 No 22 Accident 8-19-2000 281. Location (Streat and Number or Rural Route Number, City or Town, State) 2908 Bright Seat Road 6 Could not be determined 3 Sulcida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida o the Humin 24 hours
To the Funeral Diversity filler 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the ceuse(s) and menhar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. 29e. Cartifiar Medical (Check only one) 29d. Data signed (Month, Day, Year) 29c. Licanse number 29b. Signatura and title of certifiar O.C.M.E AUG. 20, 2000 Nama and address of person who completed ceusa of death (Itany 3a) (Type, Print)
Stephen Radentz, M.D. 1111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signatura 31. Data filed (Month, Day, Year) State

**DHMH 15 Rev 6/95** 

Registra

AUG 2 9 2008



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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		Certificate of	Death	Reg. N	0.	.9110
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Physician Medical	Maurice Harris		A		27 2000	2:46 PM
Examiner	4a Facility Name (If not institution, give street and number)		4b. City, Town, or Locat	ion of Death 4	c. County of Death	
	1246 Palmer Road		Ft. Washin		Prince Ge	
Funeral Director	5. Social Security Number  229-22-6997  Usual Residence of Decedent	rs. last birthday) If Under 1 Yea Months Day	r If Under 24 Hrs. 8. Hours Min. No	Date of Birth (Month, Day, Year OV. 5, 19	9. Birthpl Count Vii	ace (State or Foreig try) Cginia
pu A		City, Town or Location			10	Od. Inside City Limits
death with the Manyland me 23e or 28e-f show creat be notified at neral Director	Maryland Prince George's		shington			1 XYes 2 No
th with the 23s or 2		10f. Zip Code 2.0	744		itizen of What Count nited Stat	
_ <u>5</u> 22 5	3 Widowed 4 Divorced If Yes, Give Year or Dates:	U,S. 13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Specify ban, Mexican, Puerto Ric o Specify:	y Yes or No- an, etc.)	14. Race - America Black, White, a Specify: Neg	atc.
72 hc 72 hc yes	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occ	upation e during most of working	16b. I	Kind of Business/Ind	lustry
led within 72 ho bygiene. bygiene. rt, fr. Wedeen Completed	Elementary/Secondery (0-12)  College (1-4or 5+) 5+	Computer S	red)		Governme	ent
e filed other vent, u	17. Father's Name (First, Middle, Last)		18. Mother's Neme (F	irst, Middle, Meide		
should be fit and Mental H marked out imatic aver	Luther Harris		Mary Si	mith		
Mar dd 2 sh th and th and T la m traum	19a. Informant's Name/Relationship (Type, Print)  Josephine L. Harris - Wife	19b. Mailing Address (Street 1246 Palmer	et and Number or Rural R			
ges 1 an it of Heal if Hem 2 or other	20a. Method of Disposition 20b	. Place of Disposition (Name of		Date 20c. I	Location - City or Tov	wn, State
Dealumiore, permit. Pages 1 ar Department of Heal Important: if them 2 any injury or other page.	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Lee's Cremator	ry 9/5		linton, MI	
Demit. Pag Department Important: any Injury other.	21. Signature of Funeral Service Licensee	22. Name and Add 4001 Bo	ress of Facility Ste		eral Home h., D.C.	
Physician /Medical Examiner	1000 mily	OTE CANO		sspretory arrest,		Approximate Interval Between Onset and Death
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aw requests been 2 show				24a. Was en eut performed?	ava	ore autopsy findings alable prior to appletion of cause death?
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lelan: The certificate rector, pag	25. Wes case referred to medicat		26. Place of Death (C	heck only one)		
Physician: This certific ral director,	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2	□ ER/Outpatient 3□ DOA	Where	V	6 ☐Other (Specify	()
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To the Hospital or Attending P within 24 hours effer death. To the Funeral Director: After toompletely filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28a. Place of Injury - At building, etc. (Special Could not be determined 28b.)	home, farm, street, factory, officity)	281.	Location (Street a City or Town, Sta	and Number or Rura ite)	l Route Number,
To the Hospital or At within 24 hours eiter of to the Funeral Direct completely filled in by	29a. Certifier (Check only one)  1					
To the Within To the compl		211, O .   29c. Lice	nse number	29d. D	ate signed (Month, L	Day, Year)
- 310	24		017548	3	7,29	06
(10)	30. Name and address of person who completed cause of death (lit.		011078			
		4 Spring St.,	100: Silver	Spring.	MD 209	10
State	31. Date filed (Month, Day, Year) 22. Registrar's Sig	nature				
Registrar	AUG 3 0 2000	D. South				

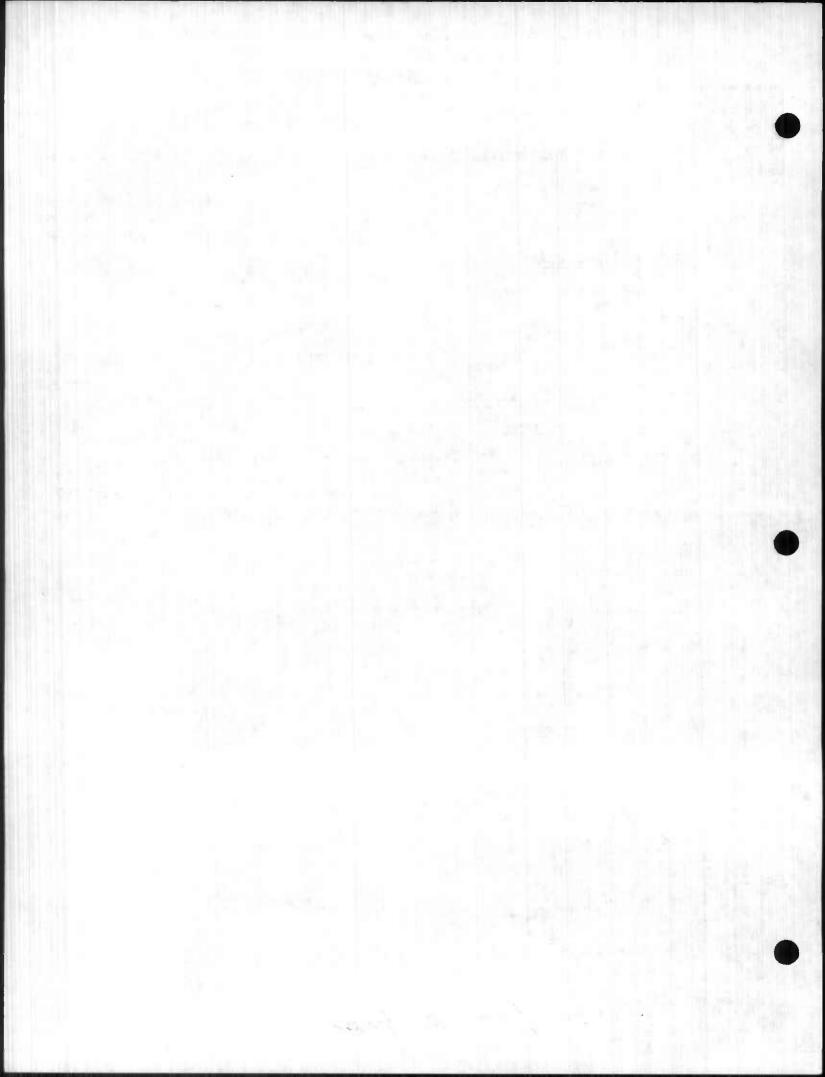
DHMH 16 Ray 6/95

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### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

			State of Marylan		artment of I		d Mental Hy	giene Reg. No.	00 :	29114	
		1. Decedent's Name (First, Middle, Las	)				2. Data of De	eath		3. Time of Death	1
	Physician	Patricia Mary	Margaret Henr	v			AUGUST	29,	Year 2000	02:19 A.	M
	/Medical Examiner	4a Facility Nama (If not institution, giva		-		4b. City, Town,	or Location of Deal			02.17 11.	77.
	Funeral Director	MALCOLM GROW MED 3  5. Social Security Number 6. Se  574 12 6231		last birthday) Yrs.	If Undar 1 Year Months Days			ay, Year)		ace (State or Foreigny)	חק
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	or 28e-f s be notified Director	10e. Streef end Number		opper	10f. Zip Code	)		10g. Citizen of \	What Countr	ry?	
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	ther death of the them 23 siner must Funeral	11. Marifal Status	12. Was Decedent Ever in U,	S. 13. V	Was Decedent of	Hispanic Origin	7 (Specify Yes or N	o- 14. Rac	e - Amarica	n Indian,	
21215-0020	by by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes  No If Yes, Give Year or Dates:		Yes, specify Cut		uerto Rican, atc.)		ck, White, e v: White		
2-0	ad within 72 ho ygiene. wer than "naturn it, the Medical Completed	15. Decedent's Edu		16a. Deced	lent's Usual Occu kind of work done	pation	unding	16b. Kind of B	usiness/Indu	ıstry	
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land	d oth	17. Fethar's Name (First, Middle, Last)					Neme (First, Middle		ne)		
Via	Ment Ment Mic e	Charles Mohan				Clai	ire Alice	Baker			
Mary	and and	19a. Informant's Name/Reletionship (T)	ype, Print)	19b. Mailin	ng Address (Stree	t end Number o	r Rural Route Numb	ber, City or Town,	Stete, Zip (	Code)	
710	and in 27	Stewart Henry (HI	JSBAND)	5007	Brimfiel	d Drive	Upper I	Marlboro	, Mar	yland 207	172
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ш	20119	How L. H	and	AL	exandria	a Ferry	Road, Cl:	inton, M	arylaı	na 20/35	
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Вох 68		that Initiated events resulting in death) Last	d	ras a consequ	delice or).						
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P.0	ires that the death certifical signed by the attending phid be detached for use as the by Physician/Med				igonying oddaa g			Yes 2 No		ebly 4□Unkno	
Division of Vital Records, P.O.	been si should						24a. Wa	s an autopsy formed?	ava	re autopsy findings ilable prior to apletion of causa leath?	
Re	s has							Yes 2 No		N/I	A
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18	after death. Director: A I in by the fu	3 Suicide 6 □ Could not be	28e. Plece of Injury - At ho	ome, ferm, str			28f. Location	(Street and Numi	ber or Rural	Routa Number,	-
	after Directification by	4 Homicide	building, etc. (Specify				City or To	own, State)			
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,	-	1 tolerto	you)		DF	3318		AUGUS'	т 20	2000	
(	(11)	30. Name and address of person who c	omplated cause of death (Item	23a) (Type			W. PERTME		27,	2000	
	10/	JOHN K. KIM, CA		/ (-)/00/		-	FORCE BAS		0762-6	6600	
	State Registrar	31. Date filed (Month, Day, Year) SEP 0 1 2000	32. Regisfrar's Signa		loans,						

DHMH 16 Rev 6/95



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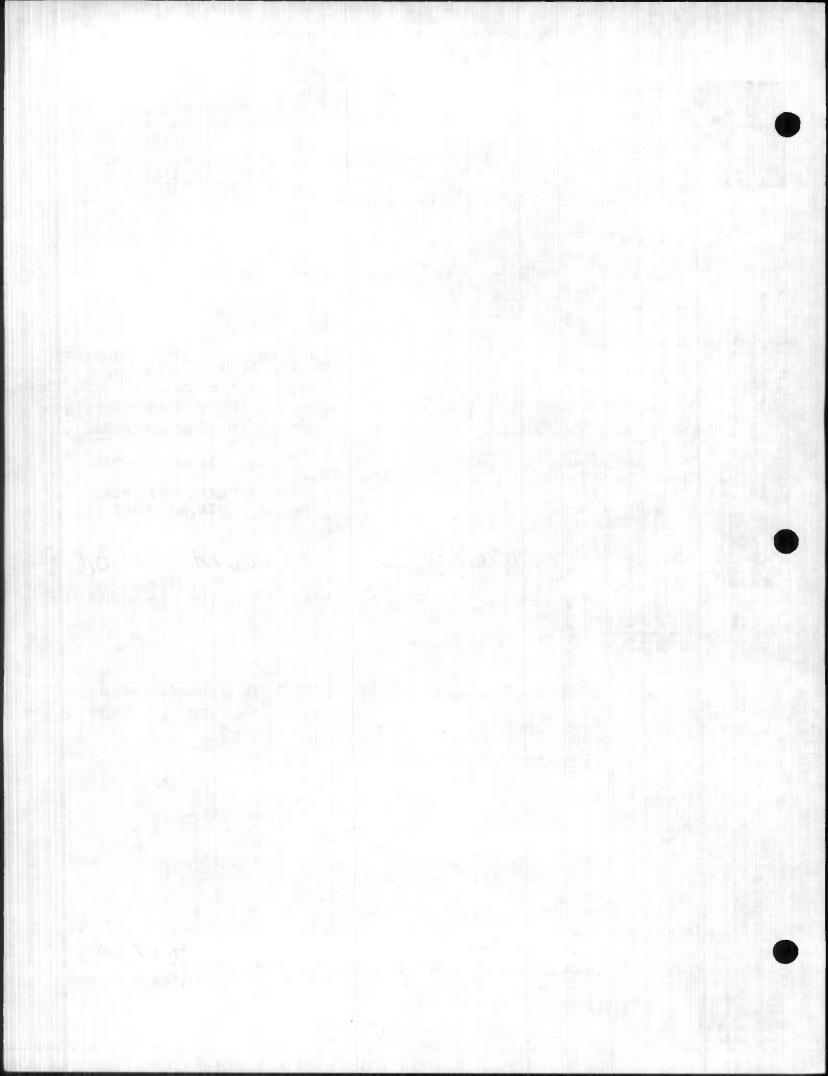
			State of Ma	rylan		partment of ertificate of		d Mental Hy	giene U	0 29115	
	1	I. Decedent's Name (First, Middle, Las	t)					2. Dete of De	ath	3. Time of Death	
Physicia		JOSEPH NICHOLA	AS HAL	TER				Septemb	per 2,2	000 10:01AM	
/Medica Examine		la Facility Name (If not Institution, give	street and number)				4b. City, Town,	or Location of Deat			
		Southern Mary		pita	1 C		Clin			ce Georges	
Funeral Director		5. Social Security Number 6. Security Number 166-18-6039	7. Age	84	ast birthda Yrs	Months De		lin. (Month, De	1,1916	9. Birthplace (State or Foreign Country) Pennsylvani	
with the Maryland a or 28a-f show be notified at	1	10a. Stele 10b. County  MD Charle	29			Location Otte Ha	11			10d. fnside City Limits 1 ☐ Yes 2 X No	
n The	Directo	De. Street and Number		011	all	10f. Zip Cod			10g. Citizen of V	Vhet Country?	
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2 ho	De de	15. Decedent's Ed	ucation		16a. De	cedent's Usual Oci ive kind of work do a. DO NOT use rel	cupetion	dina	16b. Kind of Bu	usiness/Industry	
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STOP OF	o Be (	7. Father's Name (First, Middle, Last)  John Halter						Name (First, Middle Hark Ha		Θ)	
and N		19e. Informent's Neme/Reletionship (Type, Print)  19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stele, 2									
ges 1 and t of Health If Hem 27 or other tr		Rose Halter/Wit Oa. Method of Disposition 1 XBurial 2 Cremetion 3	Date	d. Charlotte Hall, MD 20c. Location - City or Town, State							
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	+	23a. Part1. Enter the disease, or comp shock, or heert tailure. List only of	lications thet caused	the deeth	. Do not	P.O. Bo	OX 567	LA PLATA	MD 20	646 Approximate	
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hat the od by the detached	rny	ert ft. Other algnificant conditions co	ntributing to death bu	t not resu	ilting In th	e underlying cause	given in Pert I.		tobacco use co	ntribute to the cause of death?  3 Probably 4 Unknown	
he law requires that e has been signed t age 2 should be det	Completed by							24e. Was	en autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?	
	E							10	Yes 2000	1 ☐ Yes 2 ☐ No	
certificate		25. Was case referred to medical examiner?						Death (Check only	one)		
Phyalcian: this certific	0	1 Yes 2 No	Hospital: 1 Inpatier	-	ER/Outpa	tient 3L DOA		ng Home 5 □ Res			
Attending P octor: After the funer	Certification:	27. Manner of Death  1 Staturat 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		Year)	28b. Time Injur		njury at Work? I D Yes 2 Do		how injury occur		
ball or Attending its after death.  In Director: After de in by the fune	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptece ot inju building, etc	ry - At ho . (Specify	me, tarm,	street, tectory, offi	ce		Street end Numb wn, Stete)	er or Rural Route Number,	
Hospi 4 hou Funer iely fill	a calcal	29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Exam	reician: To the best of iner: On the basis of end menner sta	examinat	viedge, de ion end/o	eath occurred at the r investigation, in m	e time, date and pl ny opinion, death o	ace, end due to the ccurred et the time,	cause(s) and ma date end placa,	anner as stated. and due to the ceuse(s)	
To the within 2 To the comple	100	29b. Signature and title of certities	Ih		1100	29c. Lic	ense number		29d. Date signe	d (Month, Day, Year)	
		0	100				12906		9/2	100	
	3	0. Name and address of person who c Louis Kaufman N	1.D. 120	eth (Item	23a) (Tyr	oe, Print)	nter Su	ite 207	Walder	f MD 20602	

Registrar DHMH 16 Rev 6/95

State

31. Date tiled (Month, Dey, Year) SEP 0 5 2000

32. Registrar's Signeture



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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			Jei tillea	ie or i	Death		R	leg. No.		SMALL	
Decedent's Name (First, Middle, La  ian	st)						Data of Dea Month	th Day	Year	3. Tima of Deatl	
CHARLES	V,		1+		ART	District Control	eptem	ber 01, 2	2000	22:30	
ner 4a Facility Name (If not institution, giv	e street and number)			4	b. City, To	wn, or Locati	on of Death	4c. County	of Death		
	pkins H	ospital	_		BA	(timo					
5. Social Security Number 6. S	Sex 7. Age 120 M 2 □ F	(In yrs. last birth	Month.	er 1 Year Days	Hours	Min. 8.	Data of Birth (Month, Dey EB 21,	Year)	9. Birthpl	ace (State or Fore In) Land	
218-34-1139	ZUW ZUT	62 Y	rs.			FI	EB 21,	1938	Mary	land	
Usuel Residence of Decedent  10a. State 10b, County		10c. City, Town	or Location						11	Od. Inside City Lim	
		Elkto								1 Yes 2(	
Manyiana cccii		DINC							10.10		
Maryland Cecil  10e. Street and Number	D3		101. 2	ip Code				10g. Citizen of \			
121 East Village  11. Marital Status  1 Never Married 22 Married	_			2192				Unite			
11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Dec	ecity Cuba	in, Mexican	gin? (Specify i, Puerto Ric	Yas or No- an, atc.)		e - Amaric ck, White,		
1 Never Married 2000 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔯 N	0	1 ☐ Yes	2 XNO	Specify:			Specify: White			
	Year or Datas:	40-1	Daniel de Marie					10h Kind of D	volance floor	lunta :	
15. Decedent's Ed (Specify only highest gra			Decedent's Us (Give kind of v life. DO NOT	rork done	during most	t of working 16b. Kind of Business/Industry					
15. Decedent's E. (Specify only highest grade   Elementary/Secondary (0-12)   1.2	College (1-4or 5-	+)				chnici	an	Graphi	c Des	ian	
17. Father's Name (First, Middle, Last)	)		фито	2001			nnician Graphic Design  Name (First, Middle, Maiden Surneme)				
Bohart T Wahart						a Rose			,		
19a. Informant's Name/Relationship (	Time Print	40	Mailina Add	es (Ctrast				r, City or Town,	Cipia 7i-	Code)	
										0000)	
Lorena J. Hobart/ 20a. Method of Disposition	Wile	20b. Place of	l East		age R		Date	, MD 2 20c. Location	1921	un State	
1 Burlat 2 Cremation 3	Removal from Stata	cemetery	, cremetory of	other plea							
4 Donation 5 Other (Specif		R.A.	Ferris	& Co	., In	C. 19/4	700	West Ch	ester	, PA	
21. Signature of Funeral Service Licer	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Hicks Home for Funerals, P.A.										
Dones	& Hub	CA						lkton,	MD 2	1921	
23a. Part t. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do no	ot enter the m	ode of dyin	ng, such as	cardiac or re	spiratory ar	rest,		Approximate Interval Between	
										Onset and Death	
Immediata Cause (Final disease or condition	Hype	rkale	mia						-	Two how	
resulting in death)		Due to (or as a c		f):					1	100	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Enlst.		nal d	iscas					10	Two hou Dae Year	
Sequentially tist conditions,		Due to (or as a co								70-	
Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
Cause (Disease or injury that initiated events resulting in death) Last	c	Dua to (or as a co	onsequenca of	);							
E TOSUMA III OSAMA CASA											
	d										
Part II. Other significant conditions of	contributing to death bu	t not resulting in	the underlying	cause giv	en in Part I		23b. Dld t	obacco use co	ntribute to	the cause of dec	
Y.							101	700 2 XNO	3 Prot	pebly 4 Unkn	
yo —											
Completed by							24a. Was	an autopsy med?	24b. We	ere autopsy finding	
<u>5</u>							benoi	mou r	COI	mpletion of cause death?	
E							1 🗆 Y	es 200 No		Yes 2 No	
25. Wes case referred to medical examiner?					26 Place	of Death (C			1		
Troo been reigning to modical	Hospitel:	nt 2 ER/Out	patient 3 1	Oth Oth	or.				or (Specif	v)	
examiner?	28a. Dete of Injur (Month, Dey			28c. Injur Wor	4 🗀 140			lenca 8 Oth		//	
O 1 □ Yes 2 No		Year) In	jury M			No					
1  Yes 2 No				M 1 Yes 2 No			Location (S	Street and Numi	ber or Rura	l Route Number,	
O 1 □ Yes 2 No	n no Disso of Laiv	rv - At home, far	m. street, fact	28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)				281. Location (Street and Number or Rural Route Number, City or Town, Stete)			
O 1 □ Yes 2 No	e 28e. Place of Inju	ry - At home, far (Specify)	m, street, fact	ory, offica			City or Tow				
O 1 Yes 2 No	28e. Place of Injubuilding, etc	. (Specity)			ne dete en				anner ac el	tated	
O 1 Yes 2 No	28e. Place of Injubulding, etc.  28e. Place of Injubulding, etc.	(Specify)  f my knowledge, axamination and	death occurre	d at the tir	ne, dete en pinion, dea	d place, and	due to the d	ceuse(s) and m	anner as st	ated. the cause(s)	
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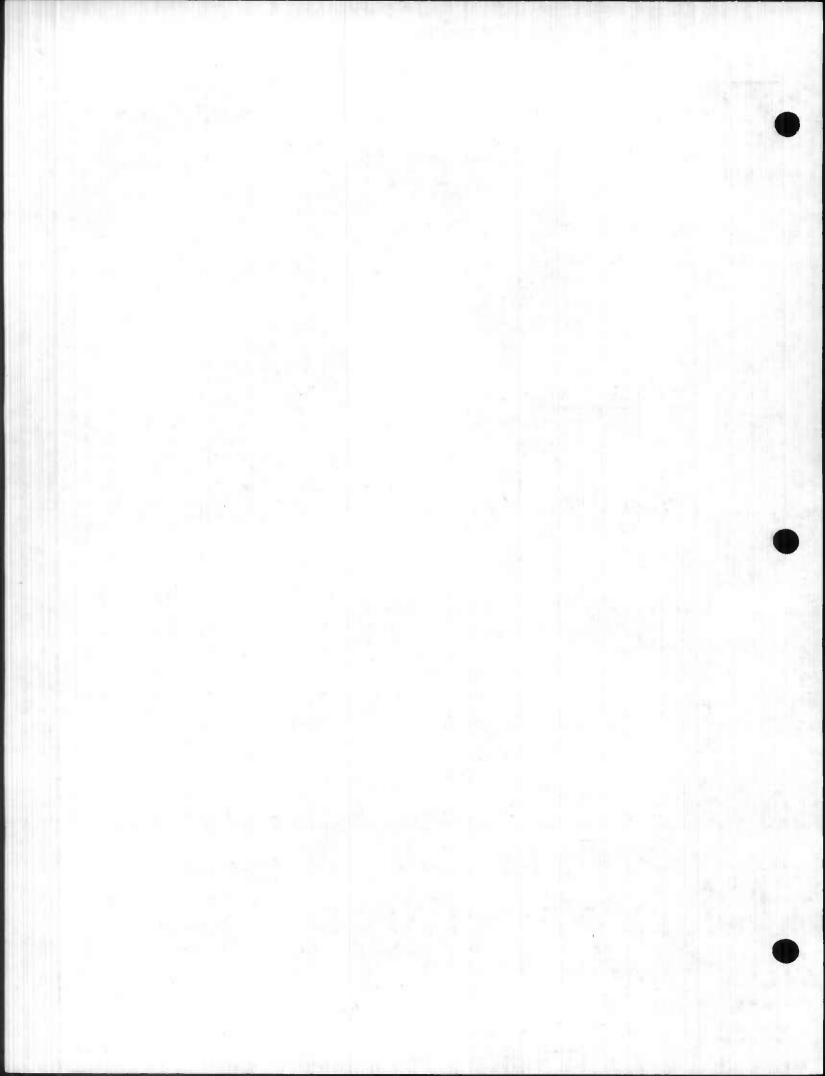
DHMH 16 Rev 6/95

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# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Detect Death

					Certi	ficate of	Death	,	Reg. No.	0 4	111
Physician	1. Decedent's Ner	me (First, Middle	, Last)					2. Dete of Dec	Day Day	Year 3. T	ime of Deeth
/Medical Examiner	William		Harvey	er)			4b. City, Town, or L	ocation of Death	4c. County	of Deeth	0554
E Adminion		n Genera	l Hospital				Fallston		Har	ford	
Funeral	5. Social Security		6. Sex 7.	Age (In yrs. le	1	If Under 1 Yeer Months Deys	If Under 24 Hrs.	8. Date of Birt	h	9. Birthplace (Country)	State or Fore
Director	233-34-0 Usuel Residence		1 <b>∑</b> M 2□F	76	Yrs.			Aug.11,	1924	West Vi	rginia
show dat	10a. State	10b. County		10c. City	, Town or Loca	tion					side City Limi
off the Ma or 28s-f be notified	Maryland		ord	Jop	pa						Yes 2/2 N
						10f. Zip Code		11 7	10g. Citizen ot V	Vhat Country?	
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her death or heme 23 sines must	1 Never Me	erried 21X Marrie	Armed Force	\$?		7.7	Hispanic Origin? (Sp ean, Mexicen, Puerto	Rican, etc.)	Blec	k, White, etc.	
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Con the			5+		7	eacher			Correct		cility
Be were	17. Father's Name	e (First, Middle, L	Last)				18. Mother's Nam	e (First, Middle,	Maiden Sumam	Θ)	
Ment Ment Marke		Dewey	Harvey					Р.		liams	
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ifficate be executed by physician and as the burial-transit	Cause (Disease of thet initieted even resulting in death)	11(5	c	Due to (or	as e conseque	nce ot):					
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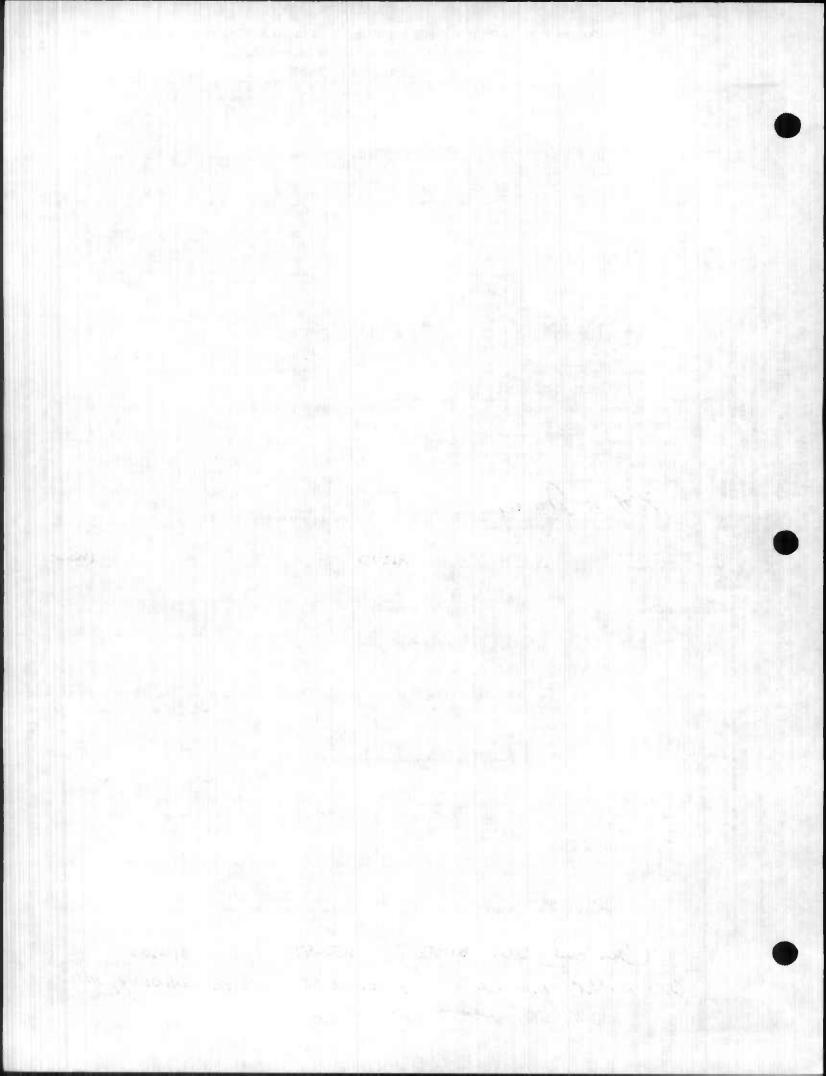
DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 00 20

an	Decedent's Name (First, Middle, Last	)	THE VEDERAL		2. Date of De	ath Day	Year	3. Tima of Death
ai	FLOYD	DILLARD	HOLLON JF	}	8	3	200	0343
er	4a Facility Name (If not Institution, give PENINSULA REGIONAL	street and number)	TD	4b. City, Town, or I				
ı							COMICO	
		7. Age (In yrs. )	Yrs. Months Day		8. Date of Bir (Month, Da July 2	25,1941	9. Birthplace Country Alab	ce (State or Foreign) Dama
	Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Location				10d	I. Inside City Limit
to	Maryland Wicomi	co Sa	alisbury					1 Yes 2 N
Irecto	10e. Street and Number		10f. Zip Code			10g. Citizen of W	hat Country	n
al Di	6084 Rockawalkin	Rd.	2180	)1		USA		
Funeral	11. Marital Status	12. Was Decedent Ever in U, Armed Forces?	S. 13. Was Decedent o	f Hispanic Orlgin? (S uban, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14. Race Biaci	- American k, Whita, etc	
29 5	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 2 Yes 2 No If Yes, Give Nav Year or Dates:	7y 1□ Yes 20XN	lo Specify:		Specify:	Whi	.te
	15. Decedent's Edu	cation	16a. Decedent's Usuel Occ	upation		16b. Kind of Bu	siness/Indus	stry
di	(Specify only highest gred Elementary/Secondery (0-12)	(e completed)  College (1-4or 5+)	(Give kind of work dor life. DO NOT use reti	ne during most of wor ired)	rking			
Completed	12	_	Wholesale Di			Automo		
Be	17. Father's Name (First, Middle, Last)	allan Cm				, Maiden Sumamo	9)	
0	-	ollon Sr			Ruther		0:4- 7:-0	- 4-1
	19a. Informant's Name/Relationship (T) Nina Hollon/Wife	/pe, Print)	19b. Meiling Address (Stree 6084 Rockaw					
Н	20a. Method of Disposition	20b. P	iace of Disposition (Name of	T	Data	20c. Location - (		
	1 Burtal 2 Cremation 3 F 4 Donation 5 Other (Specify)	temoval from State	emetery, crematory or other p Lisbury Cremat		8/21/00	Salisk		
F.	21. Signature of Funeral Service Licens		22. Name and Add	dress of Facility			-	
	1 2.4 D ()		Holloway	Funeral H				ociation
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that ceused the death	501 Snow  n. Do not enter the mode of d	Hill Rd., lying, such as cardied	Salisb c or respiretory a	ury, MD	, A	pproximete
	shock, or heart failure. List only o	ne cause of each line.					O	iterval Between Inset and Deeth
	Immediate Cause (Final disease or condition		HICUD					1 hour
	resulting In deeth)	Due to (o	r as e consequence of):					11 110
Examiner		b						
101	Sequentially list conditions.	Due to (or	r as a consequence of):					
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edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. Due to (or	r as a consequence of):					
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edicai	resulting in death) Last	d		given in Part I.	23b. Did	tobacco usa con	tributa to ti	he cause of des
edical	resulting in death) Last	d		given in Part I.		lobacco usa con Yss 2⊡ No		he cause of dead
by Physician/Medical	resulting in death) Last	d		given in Part I.	1 🖻	<b>√98</b> 2□ No	3 Probel	bly 4□Unkno
by Physician/Medical	resulting in death) Last	d		given in Part I.	1 🖹	,	3 Probe	bly 4 Unkno
by Physician/Medical	resulting in death) Last	d		given in Part I.	1 🖹 24a. Was perfo	vss 2□ No an autopsy ormed?	3 Probal  24b. Were availe comp of de	e autopsy finding able prior to pletion of ceuse eeth?
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Physician/Medical	Part II. Other significant conditions condit	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At he building, etc. (Specify lectan: To the best of my knowner: On the basis of examinat and manner steted.	ER/Outpatient 3 DOA 28b. Time of Injury M 1  ome, farm, street, factory, officion and/or investigation, in m  29c. Lice	26. Place of Decitive:  4 Nursing Figury at vork?  Yes 2 No  time, date and place of time, date and place of time, dethocouponse number	24a. Was performent of the control o	Yss 2□ No an autopsy ormed?  Yes 2□ No one)  Idence 8□Othe how injury occurr.  Street and Number win, State)  cause(s) end medate and place, a	24b. Were available of de 1 Em 1 er (Specify) ed 1 ed	bly 4 Unkn e autopsy finding able prior to pletion of ceuse reth?  Fes 2 No  Route Number, ed. ne cause(s)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Vear **Physician** TURNER HORSMAN WAYNE 28 2000 /Medical 4a Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Undar 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) November 30,1917 5 Social Security Number 9. Birthplece (State or Foraign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Maryland 1₩ M 2□ F Months Hours 214-10-7636 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Berlin Worcester 1 Yes 2 No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n USA 21811 15 Burley Street Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Rece - American Indian. Black, Whita, etc. 1 D Yes 2 No WW II If Yes, Give Year or Datas Coast Guard 1 Nevar Married 2 Married ò 1 ☐ Yes 2 ☐ No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Service Foreman C & P Telephone Co. 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middla, Last) mit. Pages 1 and 2 should be spartment of Health and Mental. portant: If Nem 27 is marked of Elrick Harrison Horsman Georgia Turner 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Burley St., Berlin, MD 21811 Berenice Horsman/Wife 20b. Piece of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, Steta 20a. Method of Disposition 1 ☐ Buriai 2 ☑ Cremation 3 ☐ Removel from Stata Salisbury Crematory 8/30/00 Salisbury, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility Holloway Funeral Home Professional Association tallecelle 501 Snow Hill Rd., Salisbury, MD 21804 Acti. Enter the disease, or complications that caused the deeth. Do not enter tha moda of dying, such as cardiec or respiretory arrest, shock, or heart teilure. List only one cause on each line. Approximete Interval Between Onsat and Death **Physician** /Medical Immedieta Cause (Final disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner C Suton Drohamo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): and attending physician for use as the buria Box 68760 Physician/Medicai Due to (or es e consequança of): the Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vitai Records, P.O. detached 1 Yes 2 No 3 Probably 4 Onknown signed by by 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy Completed performed? 1 ☐ Yes 2 No 1 Yas 2 No 25. Wes case reterred to medicel axaminer? 26. Place of Deeth (Check only one) Be To Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of 1 Natural 2 Accident Attending 5 Pending 1 ☐ Yas 2 ☐ No after death. invastigetion Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide ò To the Hospital o within 24 hours at To the Funeral Di TX Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end piace, and due to the cause(s) and menner stated. 29e. Certifier edicai 29d. Data signed (Month, Day, Year) 29c. Licansa number 29b. Signatura and 2000

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Registrar

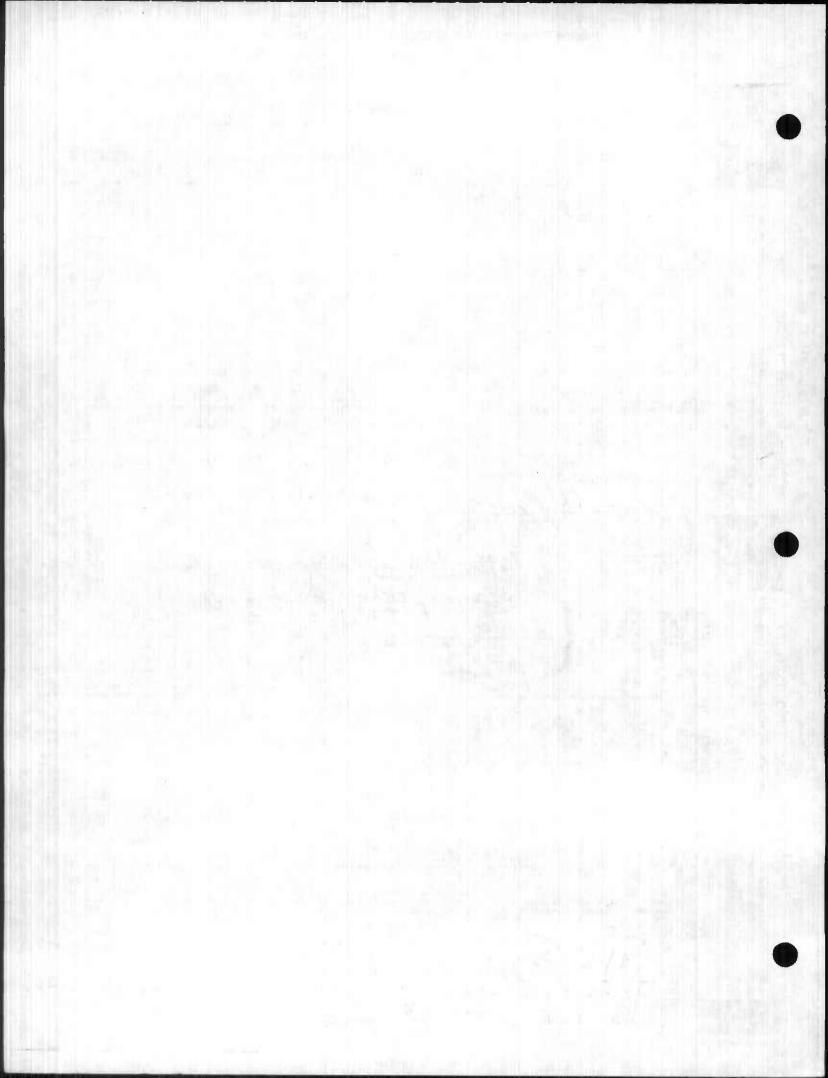
31. Date filed (Month,

MD

PRIME, Salisbury, MD

person who completed ceuse of deeth (Item 23a) (Type, Print)

therton



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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29120

Physician	Certificate of Death										
	Decedent's Name (First, Middle, L.			Month							
/Medical	MAMIE		the City Taylor	AUGUS"			5:30 P.1				
Examiner	4a Facility Name (If not institution, g						Location of Dea				
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Funeral Director	Month					Hours Mir				ace (State or Forei	
Director	Usual Residence of Decedent		102				100/10/	1090	SOUTH	CAROLINA	
ž u	10a. State 10b. County			wn or Location					10	d. Insida City Limi	
or 28a-f aho be notified at Director	MARYLAND PRINCE	GEORGES	ADELPI	HI				1 X Yas			
ar za	10e. Street and Number			10f.	0f. Zip Code			10g. Citizen of What Country?			
on lists within 22 hours are dead with Hygens, a other than "natural", or thems 23a event, the Medical Examinat must be event, the Medical Examinat must be Completed by Funeral [	1820 Metzerott Re	oad #21		20783				United States			
	11. Marital Status	Evar in U,S.	13. Was De	cedent of H	ispanic Origin? (	Specify Yes or N rto Rican, etc.)	o- 14. Rac	ce - Amarica			
	1 ☐ Nevar Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced		1 ☐ Yes 2 🖔 No Specify:				Specify: BLACK				
	15. Decedent's ( (Specify only highest g	Education rade completed)	168	a. Decedent's U	sual Occup work done	ation during most of w	orking	16b. Kind of B	usiness/ind	ustry	
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CO FF	12	1	Beautici				460 - 440 - 440	Private  irst, Middle, Maiden Sumame)			
marked other marked other matic event, To Be C	17. Father's Name (First, Middle, Las WILLIAM JONES				FRANCES		a, Maiden Sumar	ne)			
5	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing Addr	ess (Street	and Number or F	Rural Route Numi	ber, City or Town	, Stete, Zip	Code)	
		niece)				t Road,	#21, Ade				
lant: If them 27 jury or other to	20a. Method of Disposition  1208 Buriai 2 ☐ Cremation 3	Removal from State	cemate	of Disposition (i	or other pled		Date	20c. Location		wn, State	
nux	4 Donation 5 Other (Spec		GEORGI	E WASHI	NGTON	CEM.	8/26/00	Adelphi	, Md.		
any in	21. Signature of turnal Service Learning 22. Name and Address of Facility ALEXANDER S. POPE FUNERAL HOMES								W.1	2000/	
	23a. Part 1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Ma.	Approximate	
sician edical miner	Immediata Causa (Final disease or condition resulting in death)	a. (	DLDN Due to (or as a						1	Onset and Death	
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Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend # 20a, PGC 9-1-2000 cr 1. Decedent's Nama (First, Middle, Last) 2. Data of Death **Physician** JACKSON FrANK 5'.10Pm 30,2000 Aug /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Kilmer Drive Prince Georges E. LAndover If Under 24 Hrs. 8. Data of Birth (Month, Dey. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplaca (State or Foreign **Funeral** Months Days 1 M 2 F 577648632 52 Yis Feb 5 Director Usual Rasidence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yas 2 No Prince Georges LANdover WD Directo 28a-f 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 7104 8. Kilmer 20785 USA DRIVE 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Give 7 Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0020 b 1 ☐ Yes 21 No Specify Black Py d 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedenl's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Specialist Contract 12 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be 8 and Mental nokes JACKSON **YANK** MARIE 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Berlena Jackson Wite If Item 27 or other tr LANdorer, MD 20785 7104 E. Kilmer Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 6 1 Burial 2 Cremation 3 DR wal from State 9/5/200 Brestward MD 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 22. Name and Address of Facility Greene Functal Home Inc 21. Signeture of Funeral Service Licensee 814 Franklin St, Alexandria, Virginia 2314 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediata Causa (Finel diseesa or condition resulting in death) BOWEL ADENDCARGNEMA SMALL Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician sthe burial Box 68760, Physician/Medicai Due to (or as a consequence of): P.O. 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yan 25 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed 1 Yas 1 □ Yas 2 □ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) edical Certification: To 1 Yas 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 28d. Describe how injury occurred 27. Mennar of Death 28b. Tima of 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? After 5 Pending investigation 1. Byatural To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: After completely filled in by the function. 1 TYes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number of Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Newtying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as ststed.
2 Newtying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner stated.
2 Newtying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner stated. (Check only one)

State Registrar

31. Data filed (Month, Day, Year) SEP 0 1 2000

29b. Signature and title of certif

N.C

ACHUFUSI M,D 32. Registrar's Signature

30. Nema and addrass of person who completed causa of death (Item 23a) (Type, Print)

5000 N.H.

South

29d. Data signed (Month, Day, Year)

BURROUGHS AV. WAShington, D.C.

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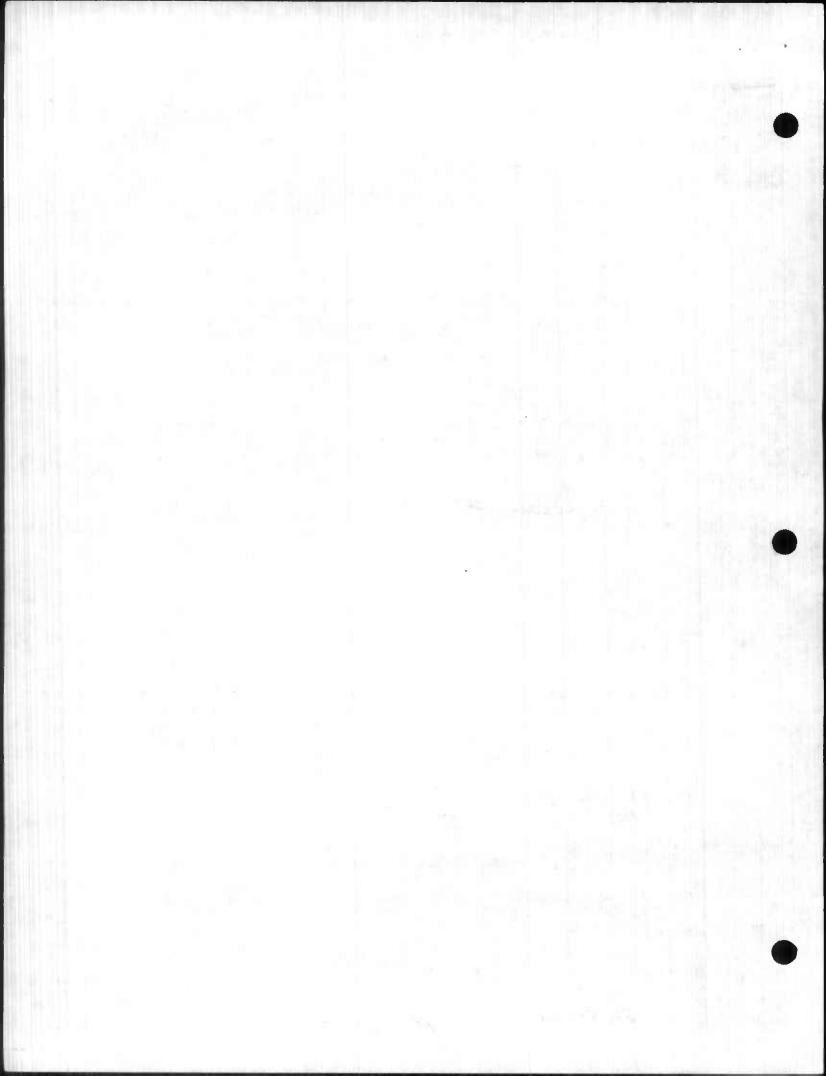
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/Medica Examine	4. English Alama (III			imber)		201	4b. City, Town, or Location of Death 4c. County of Death				7000	
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Funeral	5. Social Security No		S. Sex	7. Age (In yrs.	last birthday)	If Under 1 Y		Jnder 24 Hrs	8. Date of Bi	8. Date of Birth (Month, Day, Year) 9. Birthple		plece (State or Foreign htry)
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DIVISION OF VITAI RECORDS, P.O. BOX 58 /60, ne Hospital or Attending Physician: The lew requires that the death certificate be axecuted in 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and pletaly filled in by the funeral director, page 2 should be detached for use as the burial-transit and all controls.	Immediate Cause (Indisease or condition resulting in death)  Sequentially list confidence in any, leading to immediate. Enter Under Cause (Disease or it that initiated events resulting in death) L  Pert II. Other significant in the confidence in a cause. The confidence in a cause in a	red to medical No 1 5   Pending Investiga 6   Could no determin	AC  a. CHRONI b. CACHEX  c. CACHEX  d. Be contributing to describing to describe the contributing to describe the contributing to describe the contribution to the contribution of the con	Due to (COBSTRUCT  Due to (COBST	CHRONIC. I	pence ot): LMONARY   uence ot): uence ot): uence of):  defrying caus  at 3 DOA A 28c. M eet, factory, of	PRY FAST OF THE PROPERTY OF TH	Pert I.  Place of De late and placen, deeth occ	23b. Dice 1 24a. We perform 5 Res 28d. Describe 28f. Location City or To	I tobacco use co	24b. Was a coordinate of the c	years  years  to the cause of death?  beathy 4 Unknown  vere eutopsy findings valiable prior to ompletion of cause if deeth?  Yes 2 No  ify)  ral Route Number,  stated. to the cause(s)
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on of Vital Records, P.O. Box 68760, and Physicien: The lew requires that the death certificate be assected After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-trensit	Immediate Cause (Indisease or condition resulting in death)  Sequentially list conicause. Enter Under Cause (Disease or it any, leading to immediate. Enter Under Cause (Disease or it at initiated events resulting in death) L  25. Was case referred axaminer?  1	red to medical No 1 5   Pending Investiga 6   Could no determin	CHRONI b.  CACHEX c. CACHEX d.  Be contributing to describe the contributing to describe the contributing to describe the contributing to describe the contribution of	Due to (c. C. OBSTRUCE  Due to (c. C. C. OBSTRUCE  Due to (c. C.	CHRONIC. It is a consequence or as a consequen	pence ot): LMONARY 1 uence ot): uence ot): uence of): uence of):  defrying caus  at 3 DOA A 28c. A cocurred et the restigetion, in 1 29c. Li	PRY FAST OF THE PROPERTY OF TH	Pert I.  Place of De late and placen, deeth occ	23b. Dice 1 24a. We perform 5 Res 28d. Describe 28f. Location City or To	I tobecco use co	24b. War of the control of the contr	years  years  to the cause of death?  beathy 4 Unknown  vere eutopsy findings valiable prior to ompletion of cause if deeth?  Yes 2 No  ify)  ral Route Number,  stated. to the cause(s)

DHMH 16 Rev 6/95

Myrtle Jones



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29123

ysician		. Decedent's Name (First, Middla,	Last)						2. Date of De			3. Time of Dea	
	_	ESTELLA	ET	OURIE	,T	ACKSO	N		Month	21 Z	Yaar	12-20	
Medical aminer		a. Facility Nama (If not Institution,				2102100	-	b. City, Town, or Lo	-		nty of Death	12-20	
ammer						Bel A			Harfo	rd			
eral	5		100	Aga (In yrs.	last birthday)	If Under 1 Y	/ear	If Undar 24 Hrs.					
tor	-	216-32-5961   Jaual Residence of Dacedent	1□ M 20(F	93	Yrs.	Months D	ays	Hours Min.	8. Date of Bil (Month, De 8/30	/1906	Coun	lace (Stete or For try) unk.	
_	1	0a. Stata 10b. County	6 3	10c. Cit	y, Town or Lo	cation		72 - 7 - 4 - 1 1			1	0d. Inside City Lin	
be notified at	MD. Harford Bel A.				Bel Air	Lr							
0 8 0		10e. Street and Number 101. Zip Code 21014						10g. Citizan o					
Fa	-							21014			U.S		
by Funeral		1. Marital Status  1. Never Married 2. Married  3. Widowed 4. Divorced	12. Was Decedured For 1 Tyas If Yes, Give Year or Da	es? No	li li	Yes, specify  Yes 2		spanic Origin? (Spen, Mexican, Puerto Specify:	Pican, etc.)	Spec	lace - Americ lack, White,		
	15. Decedent's Education (Specify only highest grada completed) (Give kind of work done during most of life. DO NOT use retired)					tion	16b. Kind of But			ualness/Industry			
Completed	-	Elementary/Secondary (0-12)	College (1-	4or 5+)	life. L	OO NOT use r	etired)	uning most of work	rking				
000		6			Domestic Worke			orker	r		Home		
Be	1	7. Fathar's Nama (First, Middla, La	est)					18. Mother'a Name	(First, Middle	, Maiden Sum	eme)		
To	L	Crockett		Wolf				abeth					
		19a. Informant's Name/Reiationship	(Type, Print)		19b. Mallin	g Address (Si	treet e	nd Number or Run	al Route Numb	er, City or Tox	vn, Steta, Zip	Code 1 9390	
	M	ildred L. McM	[illan/N					ate Roa	d W	est Gr	cove,	Pa.	
	2	0a. Method of Disposition 1 ☐ Buriai 2 ☐ Cramation 3	□Demous! from C		lace of Dispo-	sition (Neme of	of r place	9)	8/26	20c. Locatio	n - City or To	wn, Stata	
		4 Donation 5 Other (Spe			berna	cle C	em	etery		Benso	on. M	arylan	
Important: if item 27 is any injury or other tra once.	2	21. Signature of Funarai Service Lice	elen A	of 1	122	22. Name and Address of Facility E.G. Kurtz & Son Funeral Home, P.A. Jarrettsville, Maryland							
ai er Jeu	1	mmediate Causa (Final disease or condition esulting in death)	â	2 2 2	r as a conseq	uence of):							
Examiner	1	Sequentially list conditions, fany, leading to immediate	e to (or as a consequence of):										
fedical	t	Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Diseasa or Injury that Initiated events resulting in death) Last  Dua to (or as a consequence of):											
Physician/W	L		d										
18/	F	art II. Other significant conditions	contributing to dea	th but not res	ulting In tha ur	darlying caus	e give	n In Part I.	23b. Dld	tobacco use	contributs to	the cause of de	
									10	Yes 2□No	3 □ Prot	pebly 4 Unk	
by Ph									24a Was	an autopsy	ava	era sutopsy findin allable prior to apletion of cause	
eted by	-			. 10.75						ormed?		death?	
Completed by Phy	-									ormed?	of		
Completed by		5. Was case referred to medical						28. Piace of Death	perfe	Yes 20 No	of	death?	
o Be Completed by	2	5. Was case referred to medical examiner? 1	Hospital: 1 □ In	patient 2	ER/Outpatien	t 3□ DOA	Othe		perfe	Yes 20 No	of 0	death? ] Yes 2 □ No	
To Be Completed by	2	examiner?  1 Yas 2 No  7. Manner of Death  1 Natural 5 Pending 2 Accident invastigat	28a. Date or (Month		ER/Outpatien 28b. Tima of Injury		Injury	f: 4□ Nursing Ho	perfo	Yes 20 No	of o	death? ] Yes 2 □ No	
o Be Completed by	2	examiner?  1 Yas 2 No  7. Manner of Death  1 Natural 5 Pending	28a. Date or (Month		28b. Tima of Injury	28c.	Injury Work	at ?  Yes 2 No	1	Yes 20 No ona) Idence 8 III how Injury occ	of of 1 E	death? ] Yes 2 □ No	
o Be Completed by	2	examiner?  1) Yas 2 No  7. Manner of Death 1 Natural 5 Pending invastigat 2 Accident 3 Suicide 6 Could not datarmine  19a. Certifiar 1 Certifying	28a. Date or (Month	Injury, Day Year) of Injury - At hog, etc. (Specify est of my knowis of examinal	28b. Tima of Injury	28c. M eet, factory, of	Injury Work 1 1	f: 4 Nursing Ho at ? /es 2 No	performance of the performance o	Yes 20 No ona)  Idence 8 00 how Injury occ  Street and Num, Stata)	Other (Specification)  The control of the control o	deeth?  ] Yes 2 □ No  //)  // Route Number,	
I director, page 2 should be of To Be Completed by	2	examiner?  1) Yas 2 No  7. Manner of Death 1 Natural 5 Pending invastigat 2 Accident 3 Suicide 6 Could not datarming  19a. Certifilar (Check only 2 Medical Ex	28a. Date or (Month) 28b. Placa or buildin 28b. Placa or buildin 28b. Placa or buildin	Injury, Day Year) of Injury - At hog, etc. (Specify est of my knowis of examinal	28b. Tima of Injury	28c. M  28c. M  occurred at the astigation, In 1  29c. Li	Injury Work 1 1 Y	A Nursing Ho at ? es 2 No a, data and piace, inion, death occurr	performance of the performance o	Yes 20 No ona)  Idence 8 00 how Injury occ  Street and Nuwn, Stata)  causa(s) and date and place  29d. Data sig	Other (Specification of Aura)  mannar as sia, and due to the control of Month, and the control of the control o	I Route Number, tated. the cause(s)	
director, page 2 should be of one of the completed by	2 2 2	examiner?  1	28a. Date or (Month) be 28e. Place of buildin  Physician: To the barand manner.	Injury , Day Year)  of Injury - At he of the control of the contro	28b. Tima of Injury oma, farm, stre  wledge, death ition and/or Inv	28c. M  eet, factory, of  occurred at the astigation, in 1  29c. Li	Injury Work 1 1 Y	the state of the s	performance of the performance o	Yes 20 No ona)  Idence 8 00 how Injury occ  Street and Nuwn, Stata)  causa(s) and date and place  29d. Data sig	Other (Specification of Aura)  mannar as sia, and due to the control of Month, and the control of the control o	yes 2□ No	

DHMH 16 Ray 6/95

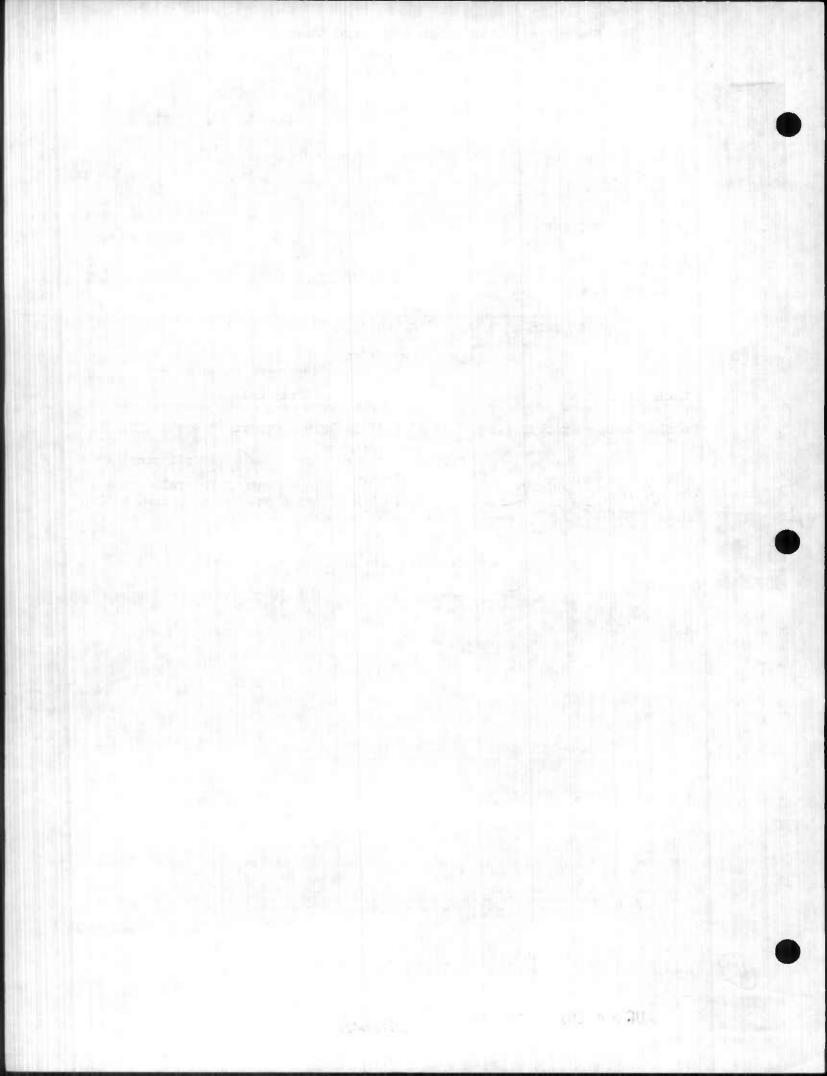
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State of Maryland / Department of Health and Mental Hygiene

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е	U	U	6	9		2	L

					001	tificate of	Dealir		6	leg. No.		
Physician	1. Decedent's Name (f	First, Middle, La	ist)					2	2. Date of Dea Month	th Day	3. Ti	me of Death
Physician /Medical	Ellen Haber Kurtz							1-				:55 PM
Examiner							Town, or Location of Death 4c. County			y of Death		
							SILVER SPRING  I If Under 24 Hrs.   8. Date of B			MONTGOMERY		
Funeral	5. Social Security Num		Sex 1□M 2√□F	7. Age (In yrs.	lest birthdey)	If Under 1 Year Months Days			3. Date of Birth (Month, Dey	Year)	9. Birthplace (S Country)	(State or Foreign
Director	5/9-62-3833 Usual Residence of De	79-62-3833						J	uly 15	, 1946	Washingt	on, DC
ž w		Ob. County		10c. Ci	y, Town or Lo	cation	-				10d. Ins	de City Limit
led a	Maryland N	Santaan.	0.3644	C	ilver S	'antac						Yes 2 N
or 28a-f1 be notifie Directo	10e. Street and Number	ontgome	ery	3.	TIVEL 5	10f. Zip Code				10g. Citizen of Whai Country?		
	401 Royalto	n Road				20901				USA		
ygene. we then *netural; or here 23 it, the Medical Examiner must Completed by Funeral	11. Mariial Status		12. Was Dec	edent Ever in U	,S. 13. V	Vas Decedent of I Yes, specify Cub	Hispanic Ori	gin? (Speci	ify Yes or No-	14. Ra	ce - American Indi	an,
	1 Never Married	2 Married	Armed Fo	2 No				n, Puerto Hi	ican, etc.)		ick, White, etc.	
	3 □ Widowed 4 5	Divorced	tf Yes, Gr Year or D		1	I□Yes 25 No	Specify:			Specil	White	
		. Decedent's E			16a. Deced	ient's Usual Occu	pation	t of working		16b. Kind of B	Business/Industry	
Med hple	Elementary/Seconda		College (1-4or 5+) (Give IIII)			kind of work done during most of working DO NOT use retired)						
Con the	12		5+		Home	Maker			Own Home			
Be Be	17. Father's Name (Fir	st, Middle, Last	")				18. Mothe	er's Name (	First, Middle,	Maiden Sumer	me)	
To the	Louis Kurt	7					Bet	ty Ze	ligson			
5	19a. Informant's Name	Alelationship	Type, Print)		19b. Mailin	g Address (Stree	t and Numbe	er or Rural	Route Numbe	r, City or Town	n, State, Zip Code)	
ar tra	Donald Kurt	z - Bro	other		8471 B	Suffalo I	Drive	Comme	rce To	wnship,	MI 4838	12
10	20a. Method of Dispos		Domousi from		Place of Disposemetery, crem	sition (Neme of netory or other pla	ace)		Date	20c. Location	- City or Town, Sta	ite
2	4 Donation 5			No	rthern	Va. Cres	matory	8/	/27/00 Arlington, Va			
the state	21. Signature de Futter	al Service Lies	PAPE O	12	22	. Name and Addr	ess of Facili		rson Funeral Home			
28	Pear								Falls Church, VA 22046			
	23a. Part1. Enter the c shock, or heart fa	disease, or con	plicat a la mat d	aused the deal	1						Appro	ximate ni Between
physician and is the burial-transit	Sequentially list conditions and the cause. Enter Underly Cause (Disease or injution interest in the cause) (Disease or injution) in death) Las resulting in death) Las		b	Due to (c	or as a consequent as a consequent	uenca of):	An	seny	yen			
detached for use as	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.							l.	23b. Did tobacco use contribute to the cause of dee			
0									101	20 No	3 ПРгобабну	4 Unkno
2 should pieted									24a. Was a	an autopsy med?	24b. Were aut available completic of death?	prior to in of cause
has been pe 2 shoul									120	es 2 No	1 Ves	2□ No
6							26. Place	of Death	(Check only o	ne)		
tor, page	25. Was case reterred	to medical	Hospitai:	tnpatient 2	ER/Outpatien	t 3 DOA	ther: 4 Nu	ursing Hom	e 5 Resid	lenca 6 🕅 Ot	ther (Specify) SC	CENE
director director	25. Was case reterred examiner?		27. Manner of Death 1 Impatient 2 En/Outpatient 3 DOA 27. Manner of Death 1 Matural 5 Pending (Month, Dey Year) 28b. Time of Injury Work 1 Accident investigation						ury at ork? 28d. Describe how injury occurred			
After this certific funeral director tion: To Be	examiner?  POXYes 2 No  27. Manner of Death  Natural  Chacident	5 Pending investigation	28a. Date (Mon			M 1	Yes 2		Di Lantina (6	Manager and Miles	haras Daniel Cont	Abonton
After this certific funeral director tlon: To Be	examiner?  **EXYes 2 No  27. Manner of Death  **Natural 2 Accident	5 Pending	28a. Date (Mon		ome, tarm, stre		Yes 2		Bf. Location (S City or Tow	Street and Num m, State)	ber or Rural Route	a Number,
Funeral Director: After this certificated in by the funeral director director.	examiner?  **XYes 2 No  27. Manner of Death  1 Natural  2 Accident  3 Suicide  4 Homicide  29a. Certifier	5 Pending investigation 6 Could not be determined	28a. Date (Mon 28e. Place build	of injury - At h	ome, tarm, stro	M 1   1   1   1   1   1   1   1   1   1	Yes 2	28 and place, and	City or Tow and due to the o	m, State) cause(s) and m date and place	nanner as atated. , and due to the ca	nuse(s)
funeral director	examiner?    X   Yes   2   No	5 Pending investigation of the determined Certifying Pt Medical Examples	28a. Date (Mon 28e. Place build	of injury - At hing, etc. (Special post of my knows as is of examina	ome, tarm, stro	M 1   1   1   1   1   1   1   1   1   1	Yes 2	28 and place, and	City or Tow and due to the o	m, State) cause(s) and m date and place	nanner as atated.	nuse(s)
funeral director	examiner?    XYes 2 No   No   No   No   No     No   No   No	5 Pending investigation of the determined Certifying Pt Medical Examples	28a. Date (Mon 28e. Place build	of injury - At hing, etc. (Special post of my knows as is of examina	ome, tarm, stro	M 1 Ceet, factory, office occurred at the trestigation, in my 29c. Licen	Yes 2	28 and place, an	City or Tow	cause(s) and made and place	nanner as atated. , and due to the ca	nuse(s)
Funeral Director: After this certification tely filled in by the funeral director director.	examiner?    XYes 2 No   No   No   No   No     No   No   No	5 Pending investigation of Could not be determined.  Certifying Ph. Medical Example of Certifier.	28a. Date (Mon 28e. Place build	a of injury - At h ing, etc. ( <i>Speci</i> best of my kno asis of examina ner staled.	ome, larm, stru ly) www.dge, death and/or inv	M 1 E eet, factory, office coccurred at the trestigation, in my 29c. Licen	Yes 2 ime, date an opinion, dea	28 and place, an	City or Tow	cause(s) and made and place	nanner as atated.  a, and due to the ca	nuse(s)
eath. or: After this certific the funeral director cation: To Be	examiner?  **XYes 2 No  27. Manner of Death  1 Natural  2 Accident  3 Suicide  4 Homicide  29a. Certifier (Check only one)  29b. Signalus and tills	5 Pending investigation of Could not be determined.  Certifying Ph. Medical Examination of certifier.	28a. Date (Mon 28e. Place build  28e. Place build  anyelclan: To the build and man	a of injury - At h ing, etc. ( <i>Speci</i> best of my kno asis of examina ner staled.	ome, larm, struy)  wiedge, death tition and/or inv	M 1 E eet, factory, office coccurred at the trestigation, in my 29c. Licen	ime, date an opinion, dea nse number	28 and place, an ath occurred	City or Tow	cause(s) and m date and place 29d. Date sign.	nanner as atated.  a, and due to the ca	ear)

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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

				or iviaryiar				Death	Mental Hy	Reg. No.	2016	- 0
	sician edical	Decedent's Neme (First, Middle Clarence	Wilto		hnert					24, 2000		O1 AM
Exa	iminer	4e Facility Name (If not institution, 4102 28th At		ım <i>ber)</i>				ib. City, Town, o Cemple H	r Location of Dea IILS	P.G.	f Death	
Fune Direc		578 28 5881	6. Sex <b>10</b> M 2□ F	7. Age (In yrs. 75	last birthday Yrs.	if Unde Months	r 1 Year Days	If Under 24 H Hours Mi		rith Year 1925	9. Birthplece (State of Washingto	r Foreign on DC
Vand		Usuel Residenca of Decedent  10a, Stete 10b, County		10c. Ci	ty, Town or L	ocation		THE P			10d. Inside Ci	
Se-f st	ed within 72 hours after death with the Maryland down.  Not than "natural", or items 23s or 28s-1 show it, the Waddell Event count be not the added Completed by Funeral Director.	MD P.G		Temple Hills					200		1 ☐ Yes	<del>2€</del> No
with th		10a. Street and Number 10f. Zip Code 20748								10g. Citizen of Wi	net Country? States	
death		11. Merifal Sfetus	12. Wes Dec	12. Wes Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispanic Origin If Yes, specify Cuben, Mexican, P					n? (Specify Yes or No-		- American Indien, , White, etc.	
020 ours afte		1 Never Merried 2 Merrie 3 Widowed 4 Divorced		2 No 19	943	1□ Yes		Specify:		Specify:	White	
21215-0020 d within 72 hours at piene. r than "natural", or		15. Decedent' (Specify only highest		)	/Givi	edent's Usu e kind of w DO NOT	ork done	during most of w	vorking	16b. Kind of Bus	iness/Industry	
CV	dwo	Elementary/Secondary (0-12)	College	(1-4or 5+)				Public	Works	Navy Ya	rd	4113
re, Maryland 2 s 1 and 2 should be filed f Health and Mental thygis fram 27 la marked other	Be	17. Father's Neme (First, Middle, L			William				eme (First, Middl le Ford	e, Meiden Sumeme	)	
Maryland 42 should be file th and Mental Hy T is merked oth	To	Clarence Wilto		t, Sr.	t9b. Mali	ing Addres	s (Street	end Number or	Rural Route Num	ber, City or Town, S	Stete, Zip Code)	
- B = 7:		Lucille Kuhnert	(WIFE)							, Marylar	nd 20748	
0 20 = 1	2	20a. Method of Disposition  1 Burlel 2 Cremetion		State	Plece of Disp cametery, cre	emetory or	other pie	Aug 28 Cemete	2000		City or Town, State  nam, Maryl	and
Baltimore, permit. Pages 1 a Department of Hea Important: If Ham	DCB.	4 Donetion 5 Other (Sp 21. Signature of Juneral Service L	married and a second	I Ma.	2	2 Name e	nd Addre	ss of Facility	e Funera	1 Home, Ir	nc 6633 Oleryland 20	d
405	a	23a. Pert Enter the disease, of a shock, or heart feilure. List of	and that	caused the deel							Approximet	
Physical /Medic Examin	cal ner	Immediate Cause (Final disease or condition resulting in death)	e		or es a conse		CT	le v	avm		Onset end I	Deall
certificate be executed rightly sicien and an expectation and an expectation and are the bursel transition.	dicai	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Lest	c		or es e conse or es a conse				3			
death certification	lan		d						1000			
O. O. the dy the	Physician/Me	Part II. Other significant condition	s contributing to o	death but not res	sulting In the	underlying	cause gh	en in Pert I.		tobacco use con Yss 2□ No	Tribute to the cause of 3 Probably 4 2	of death? Onknown
cords requires been sign	eted								24a. Wa	s an autopsy formed?	24b. Were autopsy evailable prior to completion of condeath?	to
The law	Com					(1)			10	Yes 2000	1□Yes 2€	No
Of Vital   Physician: The	8	25. Was case referred to medical axaminer?  1 Yes 200000	Hospital:	Inpatient 2	ED/Outpatie	ent 3DD	OA Oth	Ar.	Seeth (Check only	one)	r (Snacihi)	
	_	27. Manner of Deeth Naturel 5 Pending investig	28a. Dete (Moi		28b. Time Injury		28c. Inju		- 41	how injury occurre		
Division  or Attending after death. Director: After	- W	3 ☐ Sulcide 6 ☐ Could n 4 ☐ Homicide determin	ot be 28e. Plec	e of Injury - At h ding, etc. (Speci	lome, farm, s fy)	treet, fecto	ry, office		28f. Location City or T	(Street and Number own, Stete)	or Rural Route Num	nber,
Hospita 24 hours Funeral	edical C		xaminer: On the b							e cause(s) and mar s, date and place, s	nner as stated. nd due to the ceuse(s	s)
To the Within To the	M	29b. Signeture end fitte of partition				25	c. Licens	se number		29d. Date signed	(Month, Day, Year)	
12	111	30. Name and address of pursan v	no completed cau	ise of deeth (Item	m 23s) (Type	, Print)	DI	170/		924/	00.	
6	16	Frak M. Pay	( Orle	DOIL	whys.	air	1 7	203	17. W/g	hughor.	w son	44
Reg	State gistrar	31'. Date filed (Month, Dey, Year) AUG 2 8 20	09 3	Registrer's Sign	eture &	Los	d	,				

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Tony Jo Nathan Kelson 23, August 2000 11:20PM /Medical 4b. City, Town, or Location of Death 4a Facility Neme (if not institution, give street end number) 4c. County of Deeth Examiner Casey House 6001 Muncaster Mill Road Rockville Montgomery If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Nov 1, 195 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Days Hours 1 X M 2 □ F Yrs 257-96-0288 42 1957 South Carolina Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits rail, or items 23a or 28a-f show Examiner must be nothed at 1 Yes 2 □ No MD Prince George's Director Seat Pleasant 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5943 Addison Rd 20743 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status pemit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If Ikan 27 is marked other than "natural", or Itan any Injury or other traumetic avent, the Modical Energy once. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Specify: Black 1 Yea 2 No Specify: p 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Fire Fighter/ EMT 4 Government 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Father's Name (First Middle, Last) Be Dan Kelson Alma Dilbert 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Theresa Waters Kelson- Wife 5943 Addison Rd Seat Pleasant MD 20743 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State Maryland Veterans Cem 8-31-00 Cheltenham MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility J.B. Jenkins Funeral Home 21. Signeture of Furneral Service Licenses 7474 Landover RD Landover MD 20785 23e. Pert1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** tmmediate Ceuse (Final disease or condition resulting in deeth) /Medical Metastatic Adenocarcinoma 6 Months Examiner Due to (or as a consequenca of): Examine Colon Cancer 2 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Diseese or injury that initiated eventa resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en autopsy performed? Completed 1 Yes 2₺ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 DOther (Specify) Hospice 1 Yes 22 No 10 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

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death with the Maryland

Baltimore, Maryland 21215-0020

To the Hospital o within 24 hours at To the Funeral D

29b. Signature and title of certifier

29c. License number D09470

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Dey, Year) August 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

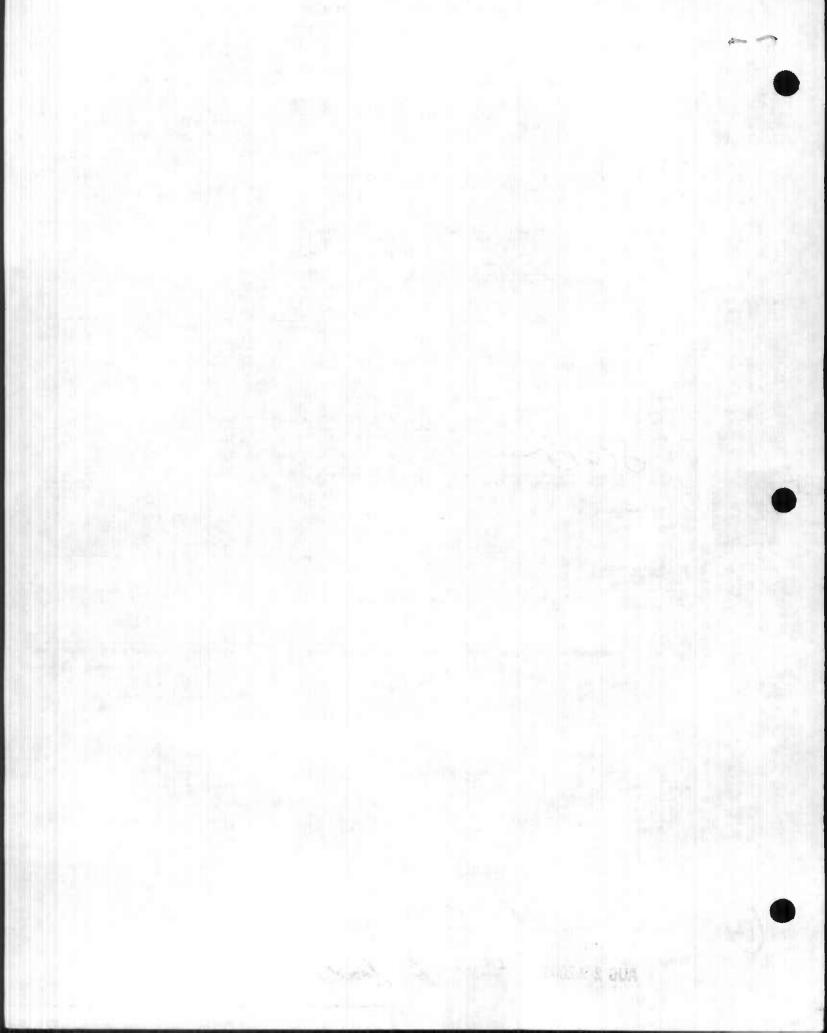
and manner stated.

Eugene P. Libre, M.D. 10400 Connecticut Avenue Kensington, MD 20895

State Registrar 29a Certifier

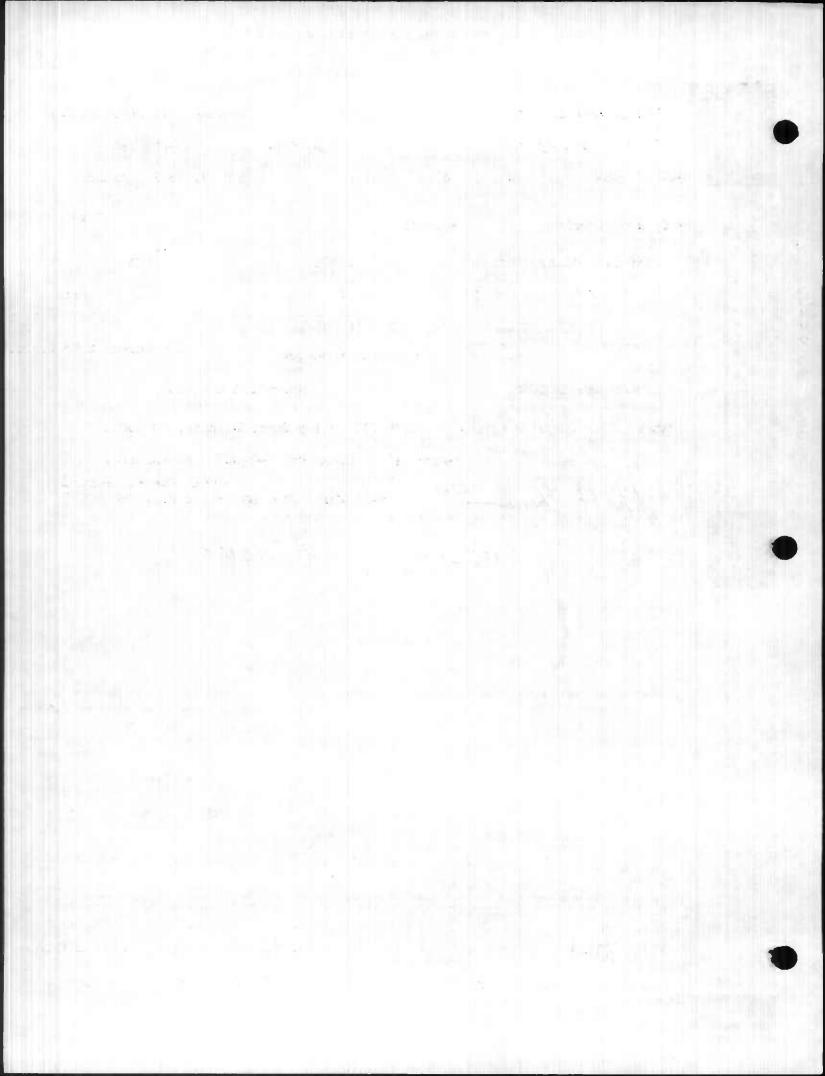
31. Date filed (Month, Day, Year) AUG 2 9 2000



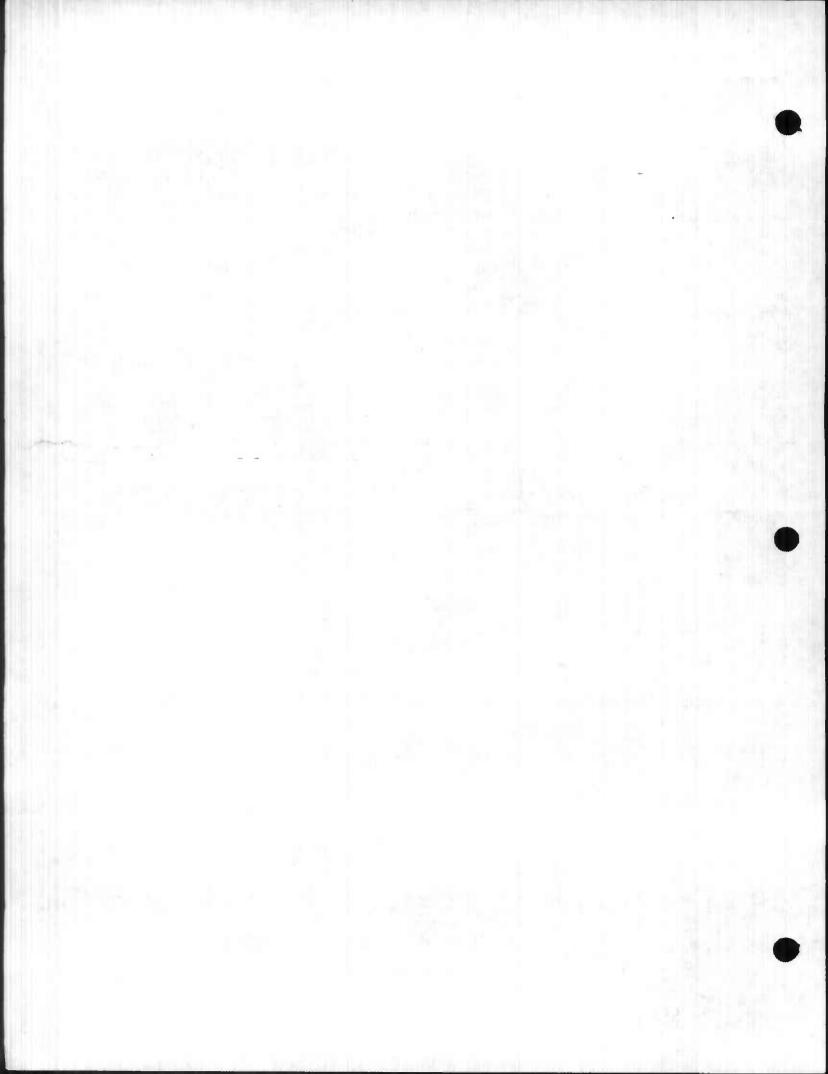


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21215-0020	should be filed within 72 hours after death with the Maryland and Mental Hygiene.  marked other than "naturel", or items 23a or 28s-f show marked other than "naturel", or items 23a or 28s-f show marked other than "nature the notified and mark that the notified and mark that the notified and the Board of the Completed by Funeral Director	15. Decedent's Edu (Specify only highast gradi Elemantary/Secondary (0-12)	cation a complated) College (1-4or 5	16a. Decedant's Usual Occupation (Giva kind of work dona during most of workin lifa. DO NOT usa ratired)  Sculptor							Produce	s sn	nall
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death 1,35 PM LIPSCOMB Month Year **Physician** 00 08 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Chevy Chase Manor Care Chevy Chase If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Dete of Birth (Month, Dey, Year) **Funeral** Months 10 M 20 F 87 Yrs. 579-01-7812 Director Oct. 18, 1912 Washington DC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow permit. Peges 1 end 2 should be filled within 72 hours after death with the Maryla Department of Health end Mentel Hyglene. Important: if item 27 is marked other than "netural", or items 23s or 28s-1 show with jujury or other traumatic evant, the Medeal Empire must be notified at once. 1 Yas 2 No Director Washington N/A 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20011 U.S.A. 3914 Kansas Ave. N.W. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give X
Year or Detes: Specify: Black Baltlmore, Maryland 21215-0020 1 Yes 2 No Specify: P 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 10th College (1-4or 5+) Clerk Treasury Dept 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 8 Maggie B. Hawkins 2 Ananias Brooks 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3914 Kansas Ave., N.W. Washington DC 20011 Norma Brown - Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 ABurial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 9-5-00 Suitland, Maryland Lincoln Cemetery 21. Signeture of Funerel Service Licenses 22. Neme and Address of Fecility Marshall's Funeral Home, Inc. 23a. Pand. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart feiture. List only one cause on each line. 4217 9th Street N.W. Washington DC 20011 Approximate tntervel Between Onset and Deeth **Physician** CEREBRO VASCULAR ACCIDENT /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner physicien and s the burlal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760. an/Medical Due to (or as a consequence of): USB Physici detached Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the causa of death? Division of Vital Records, P.O. 1 Yaa 2 No 3 Probably 4 Unknown - URINARY TRACT INFECTION: signed b þ MULTIPLE, DEMENTIA 24b. Wera eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed peen has 2 No certificate To the Hospital or Attending Physician: within 24 hours effactdeth.

To the Funeral Director: After this cantifica completely illied in by the funeral director. Be 25. Was case referred to medical examiner?

1 Yes 20 No 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Dete of Injury (Month, Day Year) 5 Pending investigation 1 Yes 2 No 2□ Accident 6 ☐ Could not be 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. adical 29e. Certifier (Check only 29c. License number 29b. Signature and title of certifier 3 GAITHERSBURG. MD: 20878. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

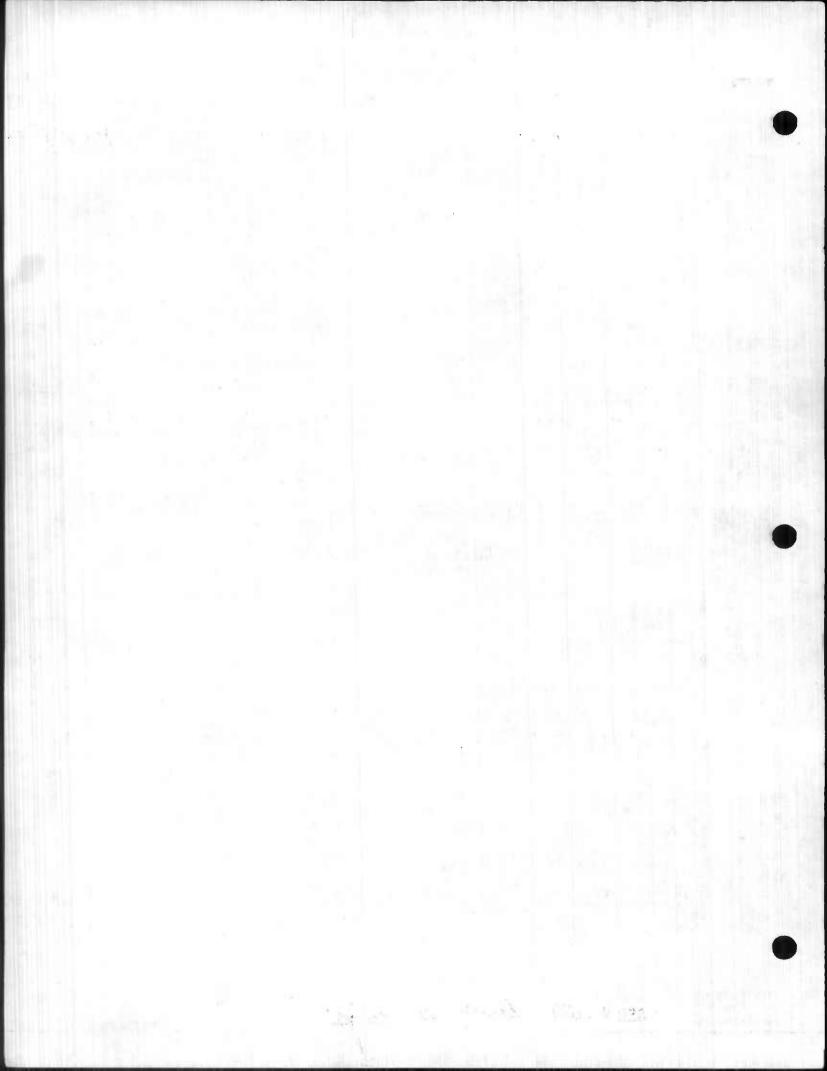
State Registrar

SEP 0 1 2000

31. Date filed (Month, Day, Year)

DARMES

KOAD SUTTE: 202, 32. Registrar's Signeture



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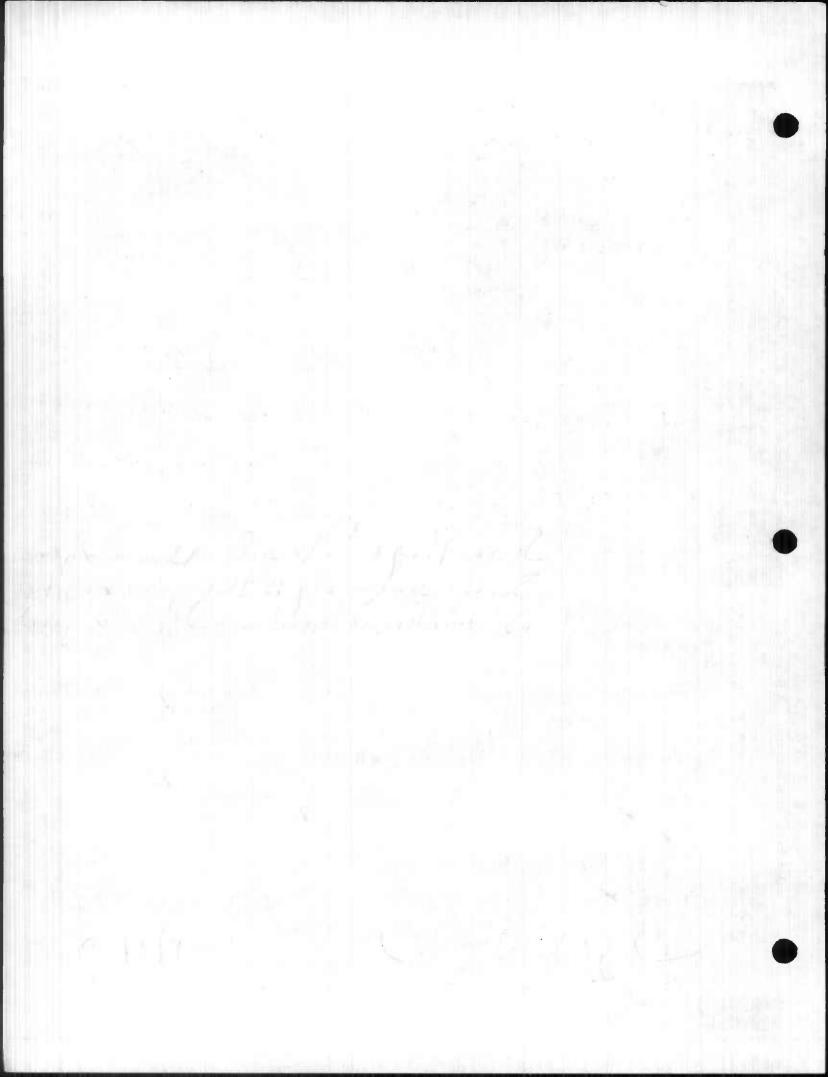
	2 Date of Death	3. Time of Des
Certificate of Death	Reg. No.	1.00
State of Maryland / Department of Health and	Mental Hygiene	29130
ype or Print in Black indelible ink. Assure A		

1. Decedent's Neme (First, Middle, Last) 3. Tima of Death SEPTEMBER 3, 2000 **Physician** LANGLEY WAI.TFR ANTHONY 5:10 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES WALDORF WALDORF HEALTH CARE CENTER If Under 24 Hrs. Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yeer 8. Date of Birth (Month, Day, Year) JULY 25, 19 9. Birthplace (Stete or Foreign **Funeral** Days Hours Months 100 M 2□ F MARYLAND Director 579-07-3200 92 1908 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at BRYANTOWN 1 Yes 2 No MARYLAND CHARLES Director 10e. Street and Number 13330 EDELEN ROAD 10f. Zip Code 10g. Citizen of What Country? ò 20617 U.S.A. "natural", or items 23s 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Nem 27 is marked other than "natural", or Nan any Injury or other traumatic svent, the Head Engineering 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: py 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE ENGINEER U.S. GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) **MARTHA THOMPSON** WILLIAM BENJAMIN LANGLEY 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P. 0. BOX 11, BRYANTOWN, MARYLAND 20617 19a. Informant's Name/Relationship (Type, Print) PATRICK E. LANGLEY/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State ST. MARY'S CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) SEPT. 7,2000 BRYANTOWN, MARYLAND 21. Signature of F neral Service Liganous 22. Name and Address of Facility
THE HUNTT FUNERAL HOME, INC. JOHN P KNISLEY BOX 156, WALDORF, MARYLAND mew M01164 P.O. 20604 23a. Pert T. Enter the disease, or complications that caused the death. Do not enter the modulal dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and the buriai-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the causa of death? been signed by the should be detach 1 Yaa KNo 3 Probably 4 Unknown py 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy parformed? completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: 25. Was case referred to medical axaminer?
1 Yes No Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 DNatural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only Medical 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) D20629 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE H. WATHEN, M.D., 11345 Pembrooke Sq, #103, Waldorf, Maryland

State Registrar

31. Dete filed (Month, Day, Year) SEP 05 2000 32. Registrar's Signature

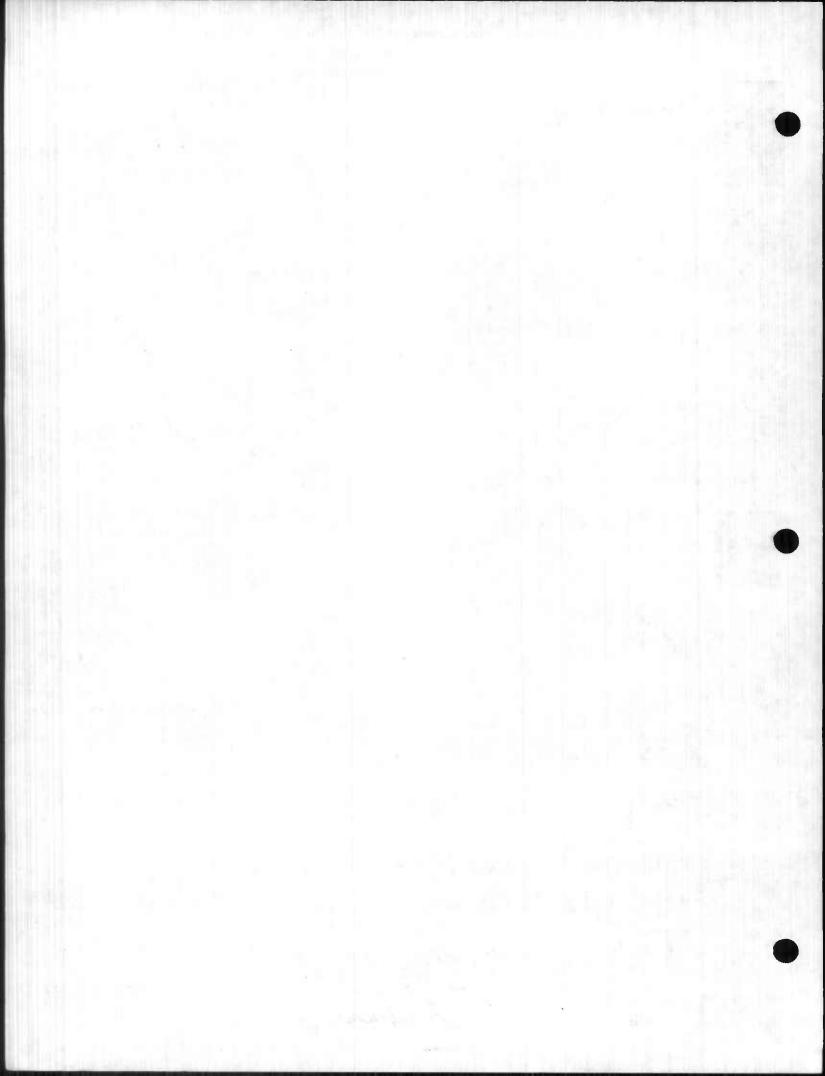


State of Maryland / Department of Health and Mental Hygiene

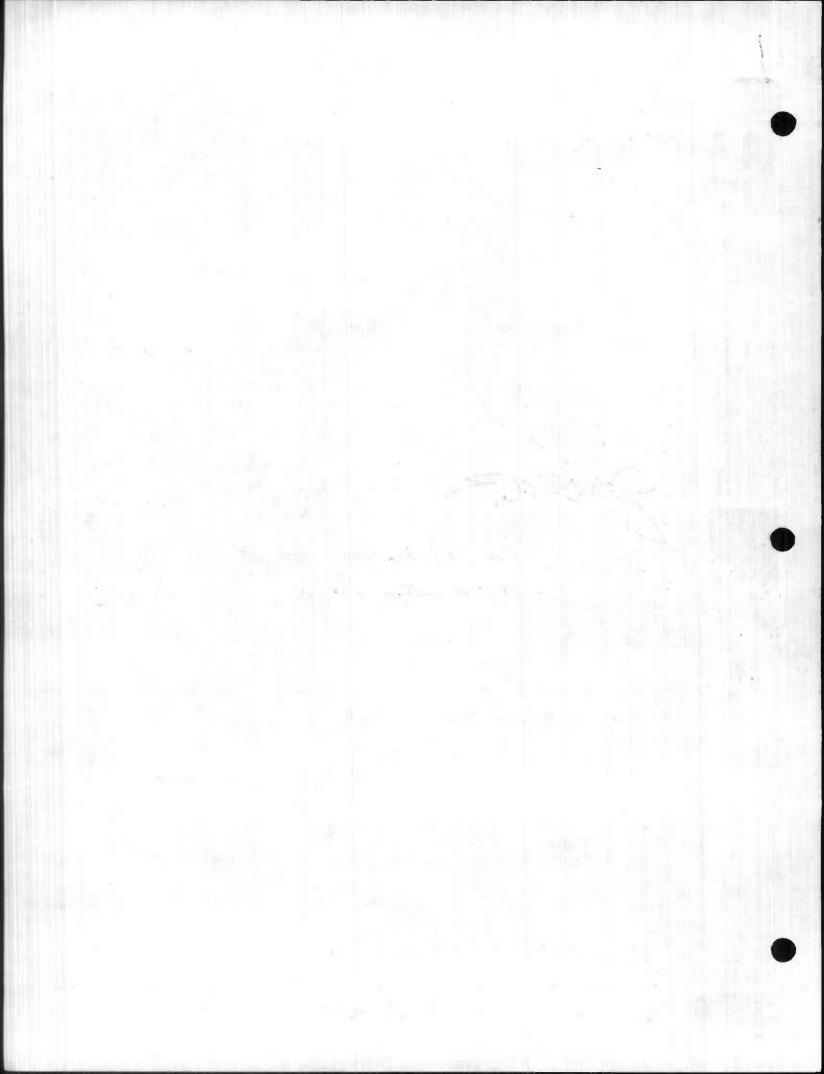
Certificate of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Day **Physician** William James Lee August 26, 2000 2:33 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner E1kton
If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Cecil Union Hospital of Cecil County 5. Social Security Number 6 Sax 7. Age (In yrs. last birthdey) Birthplaca (Stata or Foraign Country) **Funeral** 1 M 2 □ F Months Days Yrs. Director 219-22-5169 November 1,1927 Maryland Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show treumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ♥ No Directo Ceci1 Maryland North East 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò Herns 23a 150 North East Road 21901 United States Funeral filed within 72 hours after death 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: 14. Race - Amarican Indian, Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11. Meritel Status Black, Whita, atc. 1 □ Navar Merried 2 X Married Saltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Specify: py 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grade complated) United States al Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Government 12 Weapons Testing 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Surnama) Be Peges 1 and 2 should be nent of Heelth and Mental le marked Willard Earl Lee Bernice Keesey 19a. Informant's Name/Raletlonship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mem 27 150 North East Road, North East, Maryland 21901 Florence L. Lee / Spouse 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20e. Mathod of Disposition Data 20c. Location - City or Town, Stata permit. Peges Department of Important: If Its eny Injury or o Havre de Grace, 30, August 1 Buriel 2 Cremation 3 Removel from Stete 2000 4 ☐ Donetion 5 ☐ Othar (Specify) Angel Hill Cemetery Maryland 22. Nama and Addrass of Facility Crouch Funeral Home, 127 South Main Street, North East, Maryland 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intarval Batween Onset and Death Physician Immedieta Causa (Final disaasa or condition rasulting in death) /Medical Examiner Dua to (or es a conseguence of): Physician/Medical Examiner umonia The law requires that the death certificate be executed ettending physician and for use as the burial-transit Sequentially list conditions, if any, laading to immediate causa. Entar Undarlying Cause (Disease or Injury that initiated avants resulting in death) Last Box 68760. Dua to (or es a conseguança of): igned by the e P.O. Part II. Other significant conditions contributing to daeth but not rasulting in tha undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 X68 2 No 3 Probably 4 Unknown yd bengis Records, by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? page 2 certificata has 2 No 1 ☐ Yaa 2 ☐ No Division of Vital Physician: 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only ona) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) Certification: To 1 Yas 2 No apital or Attending Physical street of the s this 28a. Data of Injury (Month, Day Year) 27. Mennar of Desti 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? 1 Netural 2 Accidant 5 Pending invastigation 1 Yes 2 No 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homtcida within 24 hours To the Hospita Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiar edicai completely (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifian 29c. Licansa number 6 31. Deta filed (Month, Day, 32. Registrar's Signature State AUG 3 0 2000 Registra

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Thomas 9:18 am August 2000 Earl Logue /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13836 Turners Point Road Kent Kennedyville If Under 1 Year 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Yrs. 94 Director 222-14-9417 May 3, 1906 Wilmington, DE Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 K No Director MD 28a-f Kent Kennedyville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Berne 23a 13836 Turners Point Road 21645 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian Black, White, etc. 1 Never Married 2 Married 'natural', or Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Stationary Engineer Waterworks 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H ant: If Item 27 is marked off lury or other traumatic even Be Unknownfirst name Loque Edward Beal 19e. tnforment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret J. Logue (daughter) 13836 Turners Point Road Kennedyville, MD 21645 20e. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Riverview 8/30 4 ☐ Donetion 5 ☐ Othar (Specify) Wilmington, DE 21. Signature of Fureiral 22. Name end Address of Facility Chandler Funeral 1 2506 Concord Pike Homes e Wilmington, DE 19803 Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, or hadrit feilura. List only one cause on each line. Approximate tnterval Between Onset and Death **Physician** /Medical Immediata Cause (Fine CARDIO Pulmenary Examiner Examiner nterescleration physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or es a consequence of): the death certificate be execu Box 68760 Physician/Medical Due to (or es a consequence of): Pert fl. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? PO signed by t 1 Pres 2 No 3 Probably 4 Unknown TO BACU ABUSE IN PAST Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 s 1 Yes 2 No 1 Yes 2 No certificate Division of Vitai Hospital or Attending Physician: 24 hours after death.
 Funeral Director: After this certification by the funeral director. 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Assidence 8 Other (Specify) 1 Yes 20 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 27. Mennerof Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 DNetural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. 29b. Signature end title-of certified 29c. License number 29d. Date signed (Month, Day, Year) 2388 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) John C. ARRABATH, M.D. 223 High Street, CHEStendown, Wel. 21620 31. Data filed (Month, Day, Year) 32. Registrar's Signetyre State AUG 3 1 2000 Registrar



**Physician** 

/Medical

**Examiner** 

Directo

Funerai

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Completed

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			1 Dec	adant's Nar	a /Firet	Middle Lest)	2.0	eta of Deeth
amend	item	23a	,27	per me	G787	9/26/00 yf	Certificate of Death	Reg.
SP		-				State o	f Maryland / Department of Health and Men	al Hygie

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00	Com	9	1	3	J

**Funeral** Director the Maryland 28a-f ahon traumetic event, the Madical Examiner must be notified at ò "natural", or itema 23a Pages 1 and 2 should be filed within 72 hours after death Baltimore, Maryland 21215-0020 then . end Mentel ie marked Department of Heelth e Important: if Itam 27 le eny Injury or other trav

**Physician** 

/Medical

use as the burial-tran

attending physician

certificate

this

aral Director: After thir filled in by the funeral

Physician/Medical Examiner

by

Completed

Be

10

Certification:

edicai

Examiner

The law requires that the death certificate be executed

Box 68760.

Division of Vital Records, P.O.

To the Hospital or Attending Physicien:

death.

after

within 24 hours a

completely

Carol	Ann	Luckenbaugh

SEPTEMBER 02 Year 2000

No

3. Time of Death 1330

ST. AGNES HOSPITAL 5. Social Security Number

If Undar 1 Yaar | If Under 24 Hrs. 7. Age (In yrs. last birthday)

Yrs.

4b. City, Town, or Location of Deeth 4c. County of Death

BALTIMORE

1□ M 2□ F 186-34-4804 Usual Residence of Decedent 10a. State 10b. County

57 10c. City, Town or Location

8. Dete of Birth (Month, Day, Year) A112 . 14 , 1 Hours Min

 Birthplece (State or Foreign Country) 1943 Pennsylvania

10d. Inside City Limits

VA

Williamsburg James City 10f. Zip Code

1 ☐ Yes 2 ☐ No 10g. Citizen of What Country?

USA

10e Street and Number

11 Higginson Court 11. Marital Status

23188 Was Dacedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Deys

14. Race - American Indian. Black, White, etc.

1 Nevar Memled 2 Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Dacedent Evar In U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Detes:

1 Yes 2 No Specify

White 16h Kind of Business/Industry

15. Decedent's Education (Specify only highest greda complated) Elementary/Secondary (0-12) College (1-4or 5+) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Controller

Insurance

17. Fether's Name (First, Middle, Last)

Horace Bair

18. Mother's Name (First, Middle, Meiden Sumeme)

9/9/00

Viola Keller

19a. Informant's Name/Relationship (Type, Print)

21. Signatura of Funeral Sarvice Licensee

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)

Dwight Luckenbaugh - Husband

20b. Plece of Disposition (Name of cemetery, cremetory or other place)

11 Higginson Court Williamsburg, VA

20c. Location - City or Town, Stata

Williamsburg, VA

20e. Method of Disposition

1 XBurial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify)

Williamsburg Memorial 22. Nama end Address of Facility

Metropolitan Funeral Service, Inc.

5517 Vine Street Alexandria, VA 22310 Liter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, wheer failure. List only one ceuse on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

A HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of)

Sequentially fist conditions, if any, leading to Immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last

Due to (or es a consequence of):

Dua to (or es a consequance of)

Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Tyss 2 No 3 Probably 4 Unknown

24a. Was en autopsy performed? 2 No 24b. Were autopsy findings available prior to complation of cause of death? 2□ No

25. Was casa referred to medical Yes 2□ No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA 28e. Date of Injury (Month, Day Year)

Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Dascribe how Injury occurred

1 Yes 2 No

26. Place of Death (Check only ona)

28e. Placa of Injury - At home, farm, atreet, factory, office building, etc. (Specify)

29a. Certifier (Check only

27. Manner of Deeth

1 Natural

2 Accident

4 Homicide

3 Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. S/m

14

5 Pending investigation

6 Could not be

29c. License number O.C.M.E

SEPTEMBER 03,2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Deta filed (Month, Dey, Year)

32. Registrar's Signature

State Registrar

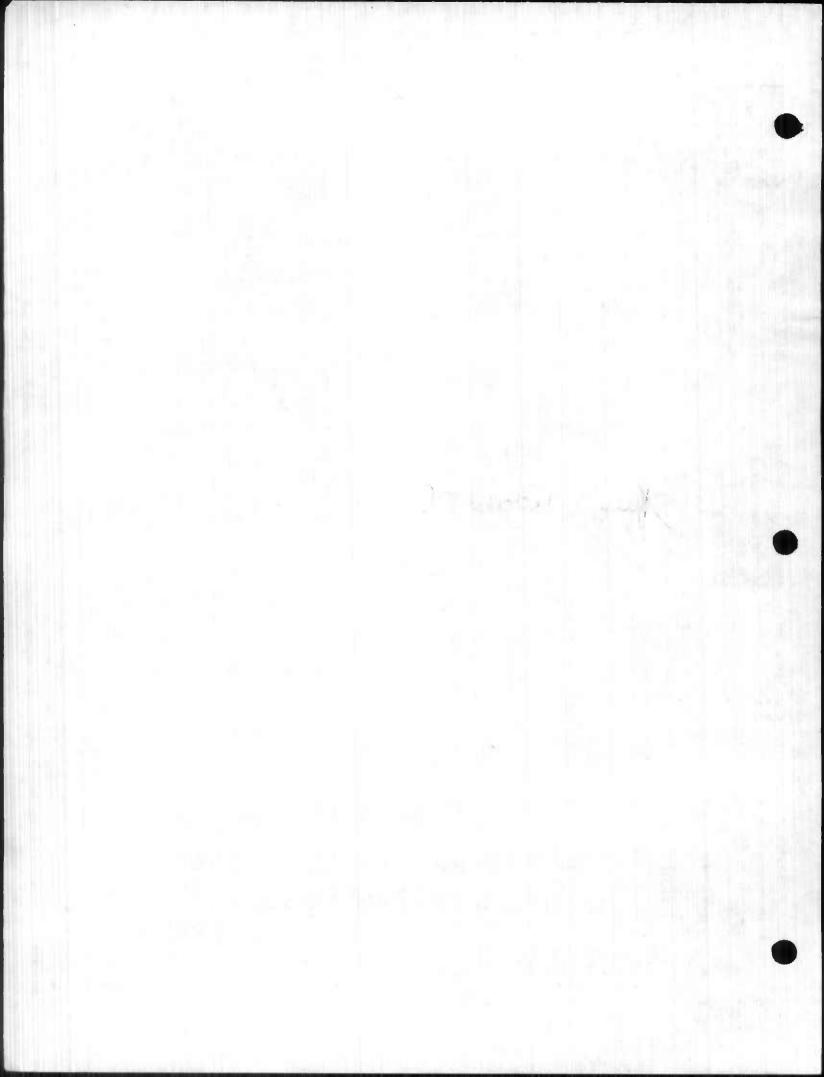
**DHMH 16 Rev 6/95** 

**ORIGINAL** 

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

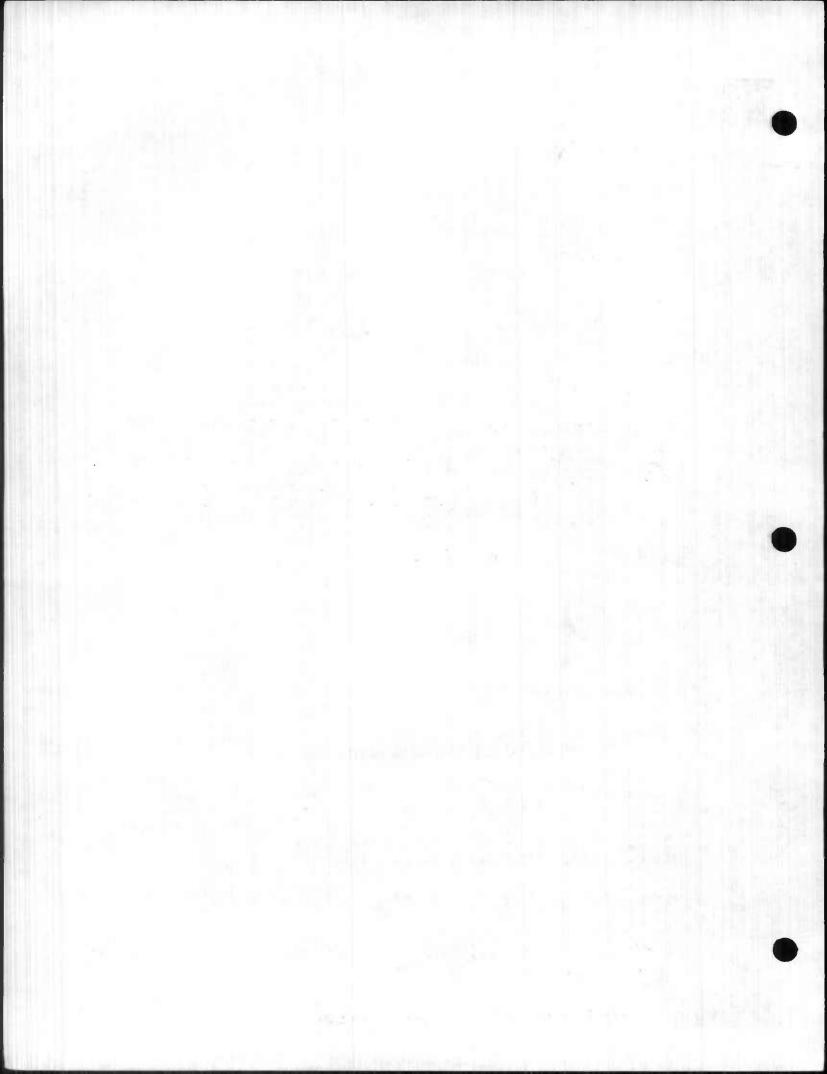
111 Penn Street, Baltimore, Maryland 21201



amend item 25 per phys. G787 9/14/00 yf Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Ella Eugenia Loughlin 30 2000 June 6:30 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mariner Health of Forest Hill Forest Hill Harford If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 10M 25F Hours 217-32-8633 82 Director Dec. 29, 1917 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits v 25a-f show a notified at show 1 ☐ Yes 2 No Directo Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Berns 23s or must be 11 Kennard Avenue 21040 USA 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. the Medical Exeminer Black, White, etc. 1 Yes ZZNo If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White å 3℃Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/Operator Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Pages 1 and 2 should be fit mant of Health and Mantal H ant: If them 27 is marked off lury or other traumatic even Be Clarence E. Cullum Katherine I. (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 2127 Bellvale Rd., Fallston, MD 21047 Michael J. Loughlin, Son 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20c. Location - City or Town, Stata 1 ☑ Burial / 2 ☐ Cremation 3 ☐ Removel from State Department of Important: If any injury or other. 4 Donation 5 Other (Sp. Cokesbury U.M. Cemetery | 7-3-00 | Abingdon, Maryland 21. Signaj 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 the death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, but only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Cause (Finel probable diseasa or condition rasulting in death) puru Examine Examiner iclan and burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Box 68760. Physician/Medical Due to (or as a consequence of): esn signed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco usa contributa to the causa of death? 1 Yea 2 No 3 Probably 4 Unknown Records. by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No Division of Vitai or Attanding Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) within 2 To the 29b. Signature and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32 295 July 2, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DouiD 5. BUNN 615 W. 31. Date filed (Month, Day, Year) 32. Registrer's Signature 2000 5 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Dey Yeer 28. 2000 **Physician** AUGUST GEORGE FRANK LEFEVRE 7:12 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, give street end number) Examiner Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day), Year) 9. Birthplece (State or For Country), Nov. 18, 1911 Pennsylvania 5. Social Security Number 9. Birthplece (State or Foreign **Funeral** 1₩ 2□F 206-03-9361 **Director** Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location t0d. Inside City Limits r than "netural", or items 23s or 28s-f show the Wedsal Examiner must be notified at 1X Yes 2 No Director Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 159 Mt. Royal Avenue 21001 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Stetus filed within 72 hours after 1 X Yes 2 □ No
If Yes, Give
Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Cotlege (1-4or 5+) Ordinance Engineer U.S. Government 12 7 is marked other traumatic evant, permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic evant page. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Frank LeFevre Sylna Heurotin 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. informant's Name/Relationship (Type, Print) Harry Webster (Caregiver) 3414 Walnut Rd., Aberdeen, Maryland 20b. Ptece of Disposition (Neme of cemetery, cremetery or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete Buriel 2 Cremetion 3 Remove from State Harford Memorial Gardens 9/2/00 Aberdeen, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licenses 22. Name and Address of Fecility
Tarring—Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Pen1. Enter the disease, or comprise that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only the cause on each line. Approximete tnterval Between Onset end Death Physician RESPIRATORY FAILURE Immediate Ceuse (Final disease or condition resulting in deeth) HOURS /Medical Examiner Due to (or es a consequence of): Physician/Medical Examiner PNEUMONIA DAYS The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): Box 68760, CHOLECYSTITIS DAYS thet initieted events resulting in death) Last Due to (or as a consequence of): use as the CORONARY ARTERY DISEASE YEARS P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown á STATUS POST CORONARY BYPASS SURGERY Be Completed by of Vital Records, 24b. Were eutopsy findings 24e. Was an autopsy performed? VALVULAR HEART DISEASE available prior to completion of cause of death? 1□ Yes 2 No 1 Tes 25 No Hospital or Attanding Physician: 25. Was cese referred to medical axaminer? 26. Place of Death (Check only one) Hospitei: 1 Unpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 25 No this Certification: 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1) Naturet 5 Pending investigation safter death. 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral ( Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. edicai 29a, Certifier completely To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 31826 6005-85-8 TICKL MIT 30. Name end address of person who completed ceuse of death (Item 23e) (Type, Print) 441 RICHARD LINTHICUM, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND

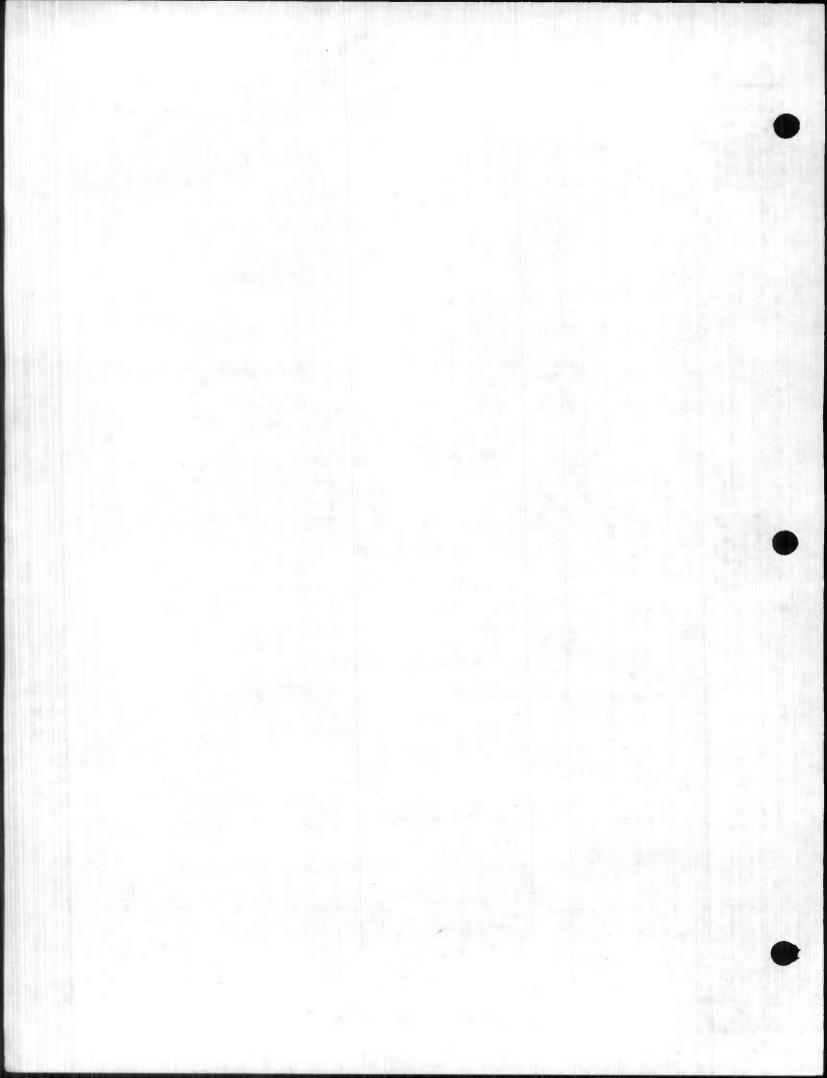
DHMH 16 Ray 6/95

Registrar

31. Dete filed (Month, Dey, Year)

AUG 2 9 2000

32. Registrer's Signeture



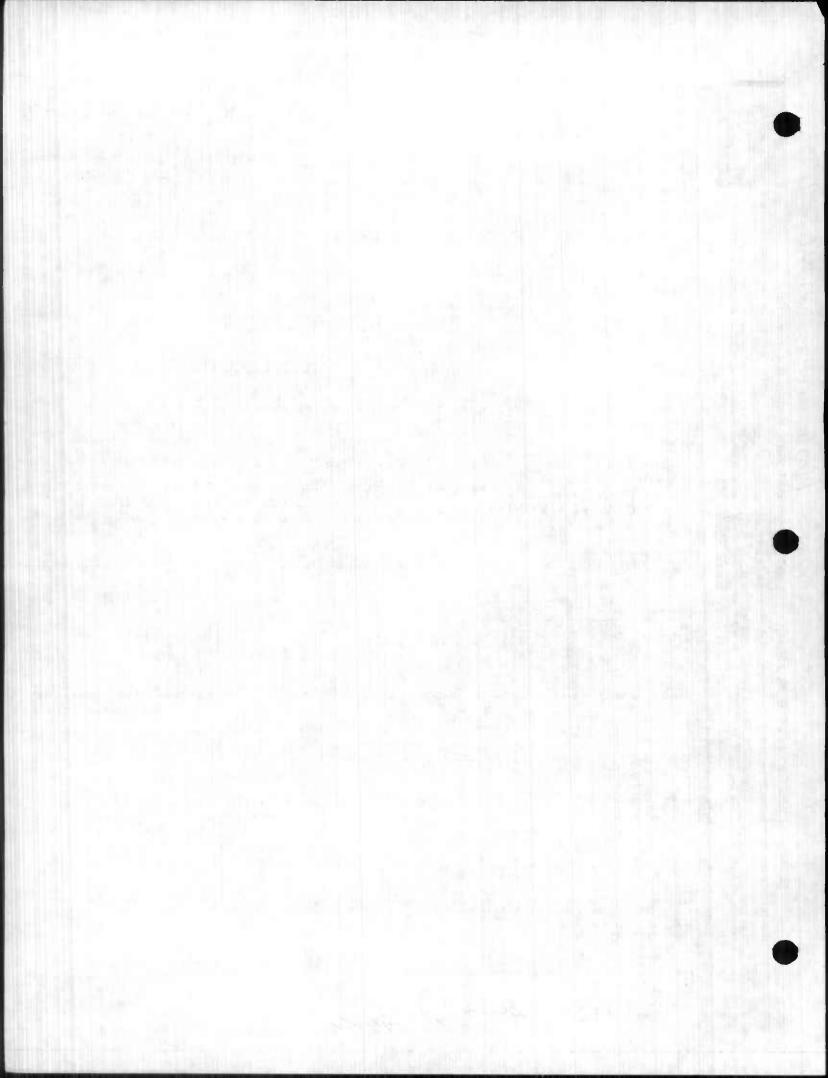
State of Maryland / Department of Health and Mental Hygiene

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			Cer	tificate of l	Jeath	R	eg. No.	
Physician	1. Decedent's Name (First, Middle, Las		TELLO			2. Dete of Deat Month		3. Time of Death
/Medical	WILLIAM	THOMAS	LEWIS			8	29 2	000 0323
Examiner	4a Fecility Name (If not institution, give PENINSULA REGION		NTER		b. City, Town, or SALISE	Location of Deeth	4c. County of WICOM	
Funeral Director	5. Social Security Number 6. Se 215-26-5821	ex 7. Age (In yrs. 70 70 70 70 70	last birthdey) Yrs.	If Under 1 Yeer Months Deys	If Under 24 Hrs Hours Min		Year) 28,1929	Birthplace (State or Foreign Country) Virginia
. 1	Usual Residence of Decedent	1.0 00						
ns 23a or 28a-f show must be notified at heral Director	Maryland Worcest		y, Town or Loo Snow Hi					10d. Inside City Limits 1 🖾 Yas 2 🗆 No
be notified Directo	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	et Country?
23 E	210 S. Morris Str			2186			USA	
ar, or name 23s Examiner must by Funeral	11. Meritel Stetus  1 Never Merried 2 Merried 3 Widowed 4 Divorced	H Yes Give	AVV	Was Decedent of Hi f Yes, specify Cube I ☐ Yes 2 XNo	spenic Origin? (5 n, Mexican, Puer Specify:	Specify Yes or No- rto Rican, etc.)		Amarican Indian, White, etc.
fred fred	15. Decedent's Ed (Specify only highest great	ucation	16a. Deced	lent's Usuel Occup	etion	orking	16b. Kind of Busin	ness/Industry
t, the Medical. Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired Ler Carri		nnny	II S Po	stal Service
	17. Fether's Neme (First, Middle, Last)		Lect	er carri		ma (First, Middle, I		
o Be	Nelson Lewis					le Cherr		
-	19e. Informent's Neme/Reletionship (7	ype, Print)	19b. Meilin	ng Address (Street	and Number or R	iural Route Number	. City or Town, St	rete, Zip Code)
	Catherine M. Lew	vis/Wife	210	S. Morri	s St., S	Snow Hill	, MD 218	63
	20a. Method of Disposition  1 Burial 2 XCremetion 3 4 Donetion 5 Other (Specify	Removel from State	emetery, cren	sition (Neme of netory or other plea Cremato		Dete 8/30/00		ity or Town, State
8500	Signa, Funerel Service Licent     Service Lice	Moios	5	501 Snow	Hill Rd.	, Salisb	ury, MD	1 Association 21804 Approximate Interval Between
ian cal ner	Immediate Cause (Finel disease or condition resulting in deeth)	a. A THERO.  Due to (o	SCLER or as a conseq		VASCO	JLAR	DISENS	Onset end Death
s the burial-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury		r as a conseq	uence of):				1
ched for use as the bu	thet initiated events resulting in death) Last	Due to (o	res a consequ	uenca of):	1/13/			
for us								
Physician	Pert II. Other eignificant conditions co				en in Part I.			ibute to the cause of death?  B Probably 4 Unknown
dre has been signed by the are page 2 should be detached for Completed by Physicia						24a. Wes e perform		24b. Were autopsy findings available prior to completion of cause of death?
rector, page 2						1 🗆 Ye	es 2 No	1 Yes 2 10
BeC	25. Was case referred to medical		100		26. Place of De	eeth (Check only on		
0	examiner?	Hospitel: 1 ☐ Inpetient 2 ☐	ER/Outpetien	t 3 DOA Oth	ar:	Home 5 ☐ Reside		(Specify)
ation: 1	27. Manner of Death  1  Neturel 5 Pending 2 Accident investigation		28b. Time of Injury	Wor	yat k? Yes 2 No	28d. Describe ho	ow injury occurred	d
Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, ferm, stre	eet, lactory, office		28f. Location (St City or Town	treet end Number n, Stete)	or Rurel Route Number,
completely filled in by the funeral Medical Certification: 1	29e. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	veician: To the best of my kno iner: On the basis of examine end manner steted.	wiedge, deeth tion end/or inv	occurred at the timestigation, in my o	ne, date end place plnion, deeth occ	e, and due to the courred at the time, d	ause(s) and mannate end pleca, an	ner es stated. Id due to the cause(s)
Comp	29b. Signeture end title of certifier	7	2	29c. Licens	number	2	9d. Date signed	(Month, Day, Year)
	1 amo	1 am 1	1.0	1)50	759		08/8	29/2000
,	30. Neme and eddress of person who of CHARLES FOLAS	SHADE MP	8 /08/	Print) PINEBLUI	es RO	SALIS	BURY	mp 2/801
State	31. Date filed (Month, Rey, Year)	32. Registrer's Signe						

DHMH 16 Rev 6/95

Registrar



	me (First, Middle, Gail R.							2. Date of D	20, 2000	Year	3. Tima of Dea 16:15
4e Facility Name Southern	(If not institution,	, give street and n	umber)				4b. City, Town, o	or Location of Dea		of Death George	's
5. Social Security 579–96–21	Number	8. Sex 1 ☐ M 2\(\overline{\Omega}\)F	7. Age (In yrs	s. lest birth	Banth	ler 1 Year s Days	If Under 24 H Hours M	rs. 8. Date of B	irth 1971 1956	9. Birthple	rgton, D.
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	rried 2 Marrie	Armed F ed 1 Tes If Yes, C	2 <sup>™</sup> No Sive	U,S.	If Yes, sp	edent of heecify Cub	an, Mexican, Pu	(Specify Yas or N erto Rican, etc.)	Blac	e - American ck, White, et	ic.
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Elementary/Sec 12th or		College	(1-4or 5+)		HOuse	ife			Damest	tic	
17. Father's Name	(First, Middle, L						18. Mother's N	lame (First, Middle	e, Maiden Sumam P. Miller	ne)	
1-11-0		Carnett									
Mr. John	Name/Reletionsh D. McCain	i, Jr. (Hus	(band)	1969	24 Elfir	ss (Street AVEN	and Number or Le Capita	Rural Rouge Num. L Heights,	Maryland	Stato 743	Code)
		3 Removal from	n State	Plece of the complete of the c	Disposition (No. cremetory of	leme of r other pla 11 Cen	etery	8/24/200	20c. Location - O Suitland		
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mar miliated even	Last	c	Due to (	(or as a co	onsequenca o	(): ():			d tobacco use co	ntribute to	the cause of d
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DHMH 16 Rev 6/95

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

08/20/w@/6:15

mc Can, Dail

Dr. Remoner

State of Maryland / Department of Health and Mental Hygiene

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			C	ertifica	te of i	Death			Reg. No.			
Physician /Medical	Decedent's Name (First, Middle, La     REGINA FANN)		LL					2. Dala of De Month August	Dey	Year 2000		a of Death
Examiner	4a Facility Name (If not institution, giv	a street and number,	)		4	b. City, To	wn, or Lo	ocation of Death	4c. Co	unty of Death		
	Fort Washington	Hospital			F	t. Was				nce Ge	orge'	S
Funeral Director	5. Social Security Number 6. 5 579-74-1996	Sex 7. And 1	ga (In yrs. last birthda 44 Yrs.	Month	er 1 Year Days	Hours	24 Hrs. Min.	8. Date of Bird (Month, Da March	h y, Year) 2,1956	9. Birth Cou Wash		on, D.
7	Usual Residence of Decedent											
of with the Marylan 23a or 28a-f show ust be notified at ral Director	Maryland Prince Go	eorge's	Oxon Hi									e City Limits  Yes 2 No
or 28e-fr or 28e-fr be notified Directo	10e. Street and Number			10f. Z	ip Code	6 1-15			10g. Citizen	of What Cou	ntry?	
and	548 Wilson Bridge	Drive, #	B-2	2	20745				U.S.	.A.		
her dea	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1 ☐ Yas 2 ☑ If Yes, Giva Yaar or Datas:		If Yas, sp	edent of H ecify Cubs	ispanic Orig an, Mexicen Specify:	gin? (Spo , Puarto	ecify Yas or No Rican, alc.)		Race - Amari Black, White, ecity: Blac	etc.	٦,
od sales			16a De	cedent's Us	ual Occup	ation			16b. Kind	of Business/In	dustry	
Maryland 21215-0020 tid should be fised within 72 hours at the and Mental Hygiene. This marked other than "natural", or traumatic event, the Medical Exam To Be Completed by F	(Specify only highast gra Etementary/Secondery (0-12)		5+) (Gi	Clerl	vork done o use retired	du <i>ring</i> most	of work	ing		rnment		
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Be seed	Rev. Eugene Mar					Fani		Christ		monto,		
Tyla nould Mannarha marks marks				101 0 1-0	(0)						o Codes	
Ma San	19a. Informant's Name/Relationship (							al Route Numb				
	Tamara Marshall/	Daughter	20b. Place of Dis	Wils(	on Br	idge_l	Driv	e, Apt		Oxon I ion - City or T		
Baltimore, emil. Pages 1 a Separtment of Hea moortant: if item my injury or othe	1 Deposition 1 Disposition 3 □ 4 □ Donation 5 □ Other (Special		cometen/ c	rematory o	other plac		2	8/31		ver, Ma		
S Part S	21. Signature of Funeral Service Licer	nsee	1 2			ss of Facilit						
0 22559	J.B. JENKINS FUNERAL HOME  7474 Landover Road, Landover, Maryland 20785											
Charles and the last	23a. Part1. Enter the disease, or com shock, or heert failure. List only	plications that ceuse	d the death. Do not	enter the m	ode of dyin	g, such as	cerdiec	or respiratory a	rrest,	aryrain	Approxi	
Physician	SHOCK, OF HEER FAILURE, LIST ONLY	One cause on each	mile.							1	Onset a	nd Death
/Medical	Immediate Cause (Final disease or condition	Respi	ratory Fa:	ilure						1		
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68760, tificate be ext g physician eas the buriel.	that initiated events	C. Dua to (or as a consequence of):										
	resulting in death) Last	Metas	tatic Ova			r				i		
OX on on one on one one one one one one on		d					,			1		
Geeth deeth dfor u	Part II. Other significant conditions of	contributing to death I	out not resulting in the	underlying	ceuse giv	en in Part I		23b. Did	tobacco ua	contribute	to the cau	see of death?
that the death cered by the ettendir detached for use								10	Yee 20	No 3 Pro	bably	4 🗆 Unknow
S, F es the igned be del												
HECORGS, ne law requires to has been sign. ge 2 should be								24a. Was	an autopsy		Vere autop	osy findings
The law requirements that the second in page 2 should Completed		1 - 3		_			_	poric	miled r	C	ompletion death?	of cause
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Vital Figure 2 Processing Contificate irector, page Co	25. Was cese referred to medical					26 Place	of Deet	h (Check only	-			
	examiner? 1⊠ Yes 2□ No	Hospitel:	ent 2 ER/Outpa	tient 3	Oth Oth	or:		me 5 Resi		Other (Spec	ih.i	
0 5 5 5	27. Manner of Death	28a. Date of Inj	ury 28b. Time	of:	28c. Injur		raing Ho	28d. Describe			··y/	
on o ding Ph th. After th funeral	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Da	ay Year) Injur	У		k? Yes 2 □	No					
DIVISION ( but or Attending P rs after death. al Director: After t led in by the funers Certification:	3 Suicida 6 Could not b	ijury - At home, farm, tc. <i>(Specity)</i>	street, fact	ory, office				eation (Street and Number or Rural Route Number, v or Town, Stata)				
Hospi 24 hou Funer stely fil		tifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, end due to the cause(s) end manner as stated.  Ilcal Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.								se(s)		
To the comple	29b. Signatura and title of certifier			2	9c. Licans	a number			29d. Date s	igned (Month	Day, Yes	er)
F 3 F 8	1 Vicho E	. Her	wx hin	D-20986						t 29,		
(3)	30. Name and eddress of person who											
	Victor E. Herry	, M.D., 11	.701 Livin	gston	Road	, For	t Wa	shingto	on, MD	20744		
State	31. Date filed (Month, Day, Year)		rar's Signature	1								

State of Maryland / Department of Health and Mental Hygiene

29139 Certificate of Death

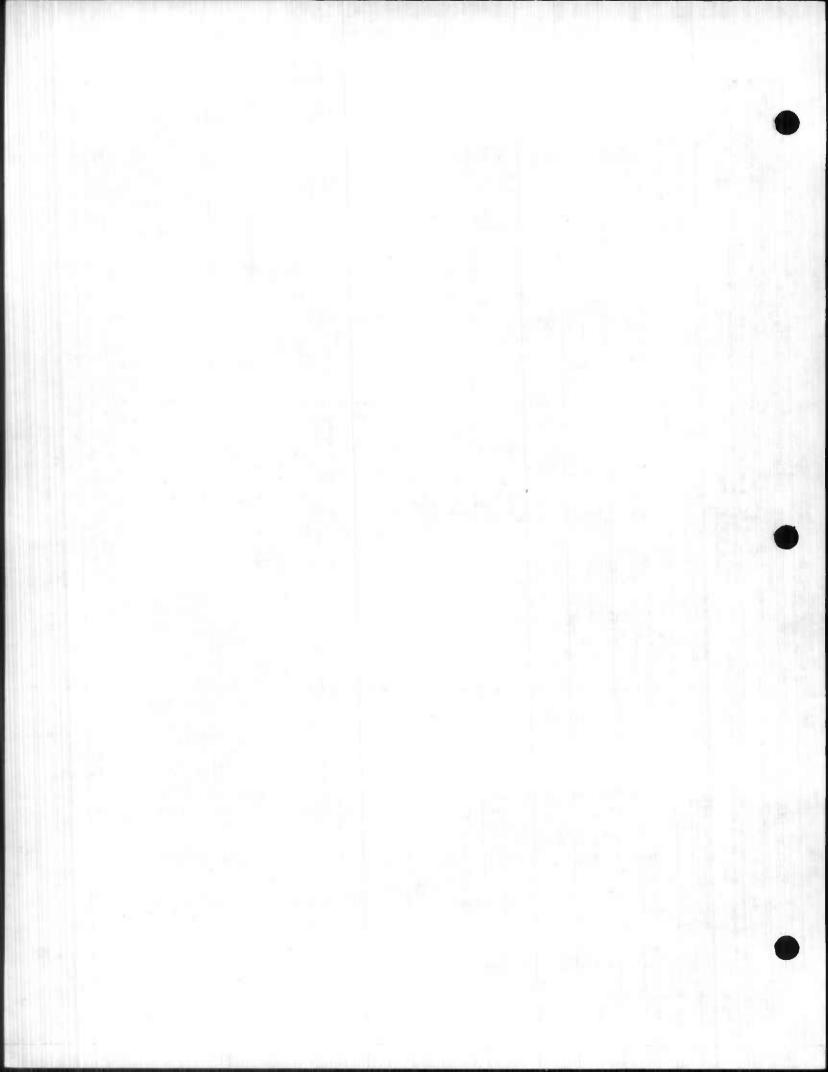
	1. Decedent's Neme (First, Middle, Last)	2. Data of Death	3. Tima of Death
Physiciar /Medica	CHARLES ANDREW MURPHY	September 1, 200	
Examine		n, or Location of Deeth 4c. County of D	
	11080 Weymouth Court, Apt. 127 Waldo		
Funeral Director	5. Social Security Number 220-28-5831 6. Sex 10 M 2 F 68 Yrs. The security Number 6. Sex 10 M 2 F 68 Yrs. The security Number 6. Sex 10 M 2 F 68 Yrs. The security Number 6. Sex 10 M 2 F 68 Yrs. The security Number 1 Sex 10 M 2 F 68 Yrs. The security Number 1 Sex 10 M 2 F 68 Yrs. The security Number 1 Sex 10 M 2 F 68 Yrs. The security Number 1 Sex 10 M 2 F 68 Yrs. The security Number 1 Sex 10 M 2 F 68 Yrs. The security Number 1 Sex 10 M 2 F 68 Yrs. The security Number 1 Sex 10 M 2 F 68 Yrs. The security Number 1 Sex 10 M 2 F 68 Yrs. The security Number 1 Sex 10 M 2 F 68 Yrs. The security Number 1 Sex 10 M 2 F 68 Yrs. The security Number 2 F 68 Yrs. The security N	Min. (Month, Day, Year)	Birthplace (State or Foreign Country) Shington, DC
E 811	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
a Man	Maryland Charles Waldorf		1 ☐ Yes 2 No
ser death with the Maryland there 23s or 28a-f show ther must be notified at tuneral Directory	10e. Street and Number 10f. Zip Code	10g. Citizen of What	Country?
五 22 元 6	11080 Weymouth Court, Apt. 127   20603	U.S.A.	
her dos c flams diner m	11. Marital Stetus  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 M Merried  12. Was Decedent Ever in U.S. 11. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, In Marital Stetus	Puerto Rican, atc.) 14. Hace - A Black, W	merican Indian, /hite, etc.
The Party of	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Yeer or Dates: 1955	Specify: W	lhite
nath edica	15. Decedent's Education 16a. Decedent's Usuel Occupation (Specify only highast grada completed) (Give kind of work done during most of life, DO NOT use retired)	f working 16b. Kind of Busine	ss/Industry
ed within 72 ho ygiene. set then "natur 4, the Medical.	Elementary/Secondary (0-12) College (1-4or 5+) Salesman	Automobil	e
ETSE S		Name (First, Middle, Maiden Sumame)	
Wents Wants of To P	Charles A. Murphy Mary	Kathleen Goldsmith	
d a d a	19a, Informent's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number		
1 and Hastin the 27	20a Mend of Special 20b Place of Disposition (Nama of	rt, Apt.127, Waldorf	
ages or of a	Compation 3 Demoval from State cemetery, cremetery or other place)	9+05-2000 Waldorf,	
Department Department Important any Injury 2008	21. Signatured Survive Service Lensee 2 22. Name and Address of Facility		, mary rana
Depart. Depart. Main my inj	MARK G. BROHAWN MOOO53 P.O. Box 156.		20004
IIIÇW	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cashock, or heart failure. List only one cause on each line.	Waldorf, Maryland ardiac or respiratory arrest,	20604 Approximate Interval Between
Physician	STOOK, OF HOUSE COLORY ONE SEASO OF BEAT WIND.		Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  a. adenocarcin ma of the liver (no	do stalie	9 months
V.	Due to (or as a consequence of):		
anacuted n and ial-transit	Sequentially list conditions  b. adout (archuma of You of Some of the of		Zypars
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d by the att fetached for	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contrib	Probably 4 Wunknown
a that so the debt of you			
The law requires that the death are has been signed by the atterpage 2 should be detached for u.	3) Aremia	24a. Was an eutopsy performed?	lb. Were autopsy findings available prior to
law r	B) Aestic ulcardisera		completion of cause of death?
idelan: The lay certificate has rector, page 2		1 ☐ Yes 2 No	1 □ Yes 2 No
Iclan: certific rector	examiner? Hoenitel:	Death (Check only one)	
this ald	1 I inpatient 2 EH/Outpatient 3 DOA 4 Nurs	ing Homa 5 Residence 6 ☐ Other (5	Specify)
tel or Attending P is after death. al Director: After led in by the funer Certification:	27. Manner of Death  1 Netural 5 Pending (Month, Day Year)  2 Accident investigation  28a. Dete of Injury (28b. Time of Injury Work?  1 Yes 2 No.		
Atter er dee ector by th	3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Could not be determined building, etc. (Specify)	281. Location (Street end Number of City or Town, State)	r Rural Route Number,
tal or in led in Certain	bulliang, atc. (Specify)	Only of Town, Olally	
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end (Check only one) (Chec	place, and due to the cause(s) and manne occurred at the time, date and place, and	r as stated. due to the cause(s)
within To the comple	29b. Signature and titlerof certifier 29c. License number	29d. Date signed (M	onth, Day, Year)
	Mary E Clean D Mordard	23 9/1/20	000
	30. Name and address of person who correlated cause of death (Item 23a) (Type, Print)		
	Dr. Stephen E. Wiggins, 12090 Old Line Center, Wald	ort, MD ZUbUI	
State Registrar	SEP 0 5 2000 Server G. Sporth		

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** CHARLES AUGUST 30 2000 EUGENE 2355 /Medical MABREY 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHESTERTOWN KENT & QUEEN ANNES HOSPITAL KENT 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours 10 M 2□ F 82 Director 265-50-3853 Maryland **Usual Residence of Decedent** death with the Meryland 10a, State 10b. County 10c. City, Town or Location ahow 10d, Inside City Limits r than "natural", or Nems 23a or 28a-f ahor the Medical Examiner must be notified at 1 Yes 2 No Director MD Kent Kennedyville 10e Street and Number 10g. Citizen of What Country? 10f. Zio Code 11942 Kennedyville Rd. 21645 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status d be flied within 72 hours effer de entel Hygiene. ed other than "natural", or flem e event, the Medical Exemple Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 25 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 K No Specify: Specify: p White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland State Hwy Elementary/Secondary (0-12) College (1-4or 5+) Laborer Administration permit. Pages 1 and 2 should be flist Depertment of Health and Mentel Hy Important: if flem 27 Is marked other by Injury or other traumatic event pages. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 James Mabrey Suzie Scuse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21645 11942 Kennedyville Rd. Kennedyville MD. Elizabeth Mabrey (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State Still Pond Cemetery 9/2/00 Still Pond, MD. 4 Donation 5 Dother (Specify) 21. Significant of Funeral Service Dong 22. Name and Address of Fecility
Galena Funeral Home of Stephen Schaech 21635 M00510 118 West Cross St. Galena, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Gause (Final disease or condition resulting in death) · Cerebrovascular accident 12 hours Examiner Due to (or as a consequence of) Examiner Cerebrovascular the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown phany ngeal edema The law requires that signed b Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed renal failure hypertension 1 Yes 1 Yas 2 No Division of Vital I Attending Physician: 25. Was case referred to medical axaminer? 8 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ☐ EPVOutpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of tnjury (Month, Day Year) 28c. Injury at Work? After 1 Natural
2 Accident 5 Pending 1 Yes 2 No death. after death Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 4 Homicide filled in 6 To the Hospital
within 24 hours a
To the Funeral C
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edical 29a. Certifie (Check only onel 29c. License number 29d. Date signed (Month, Day, Year) 25b. Signature and title of certifier Walard 55127 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 516 Washington Are Chestertown MD 21620 Margaret Valaro 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 5 2000

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 8:35 PM September 3 **JESSE** ELBERT 2000 MORGAN /Medical 4c. County of Death 4e Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner 7057 Augustine Herman Hwy. Cecilton Cecil If Under 24 Hrs. 6. Date of Birth (Month, Day, Year) If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 150 M 2□ F 143-22-0763 71 Director June 7 1929 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ahou 1 ☐ Yes 2 No Cecil Directo Cecilton 28a-f must be notif 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or hams 23s or 7057 Augustine Herman Hwy. 21913 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1☑ Never Married 2☐ Merried Maryland 21215-0020 1 Yes 2 No Specify: White Specify: þ 53-55 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 89 h and Mental I Edward Morgan Grace Cruikshank Pages 1 and 2 should 19a. Intormant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) seriment of Health important: If New 27 is any injury or other 20 is 200s. Grace Ann Beckwith (niece) Cecilton, MD. 21913 P.O. Box 515 Saltimore, 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 【Cremetion 3 ☐ Removal from State 9/4/00 Kent Cremation Smyrna, DE. 4 ☐ Donelion 5 ☐ Other (Specify) 21. Signalanti di Funeral Service Licenti Calena Funeral Home of Stephen Schaech MO0510 118 West Cross St. Galena, MD. being cations that caused the deeth. Do not entar tha mode of dying, such as cardiac or respiratory errest, only ona cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Bullous cans emphy sema disease or condition resulting in daath) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or tripiny that initiated events rasulting in death) Last and Dua to (or as a consequence of): physician Box 68760 Physician/Medical the Due to (or as a consequence of): attending | for use as P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown pulmona Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1□ Yes 28 No 1 Yes 2 TNo certificate Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica etely filled in by the funeral director, I Be 25. Was casa reterred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Plesidence 6 Other (Specify) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1□ Yes 25 No edicai Certification: To 27. Manner of Death 28a. Data of tnjury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida To the Hospital within 24 hours a To the Funeral Completely filled 10x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mennar stated. 29a. Cartifier (Check only one) 29c. License number 000 35 77 9 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8+1VA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bohemia Ave, Cecilton, Md. 21913 W. Bruce Obenshain 2515.

**DHMH 16 Rev 6/95** 

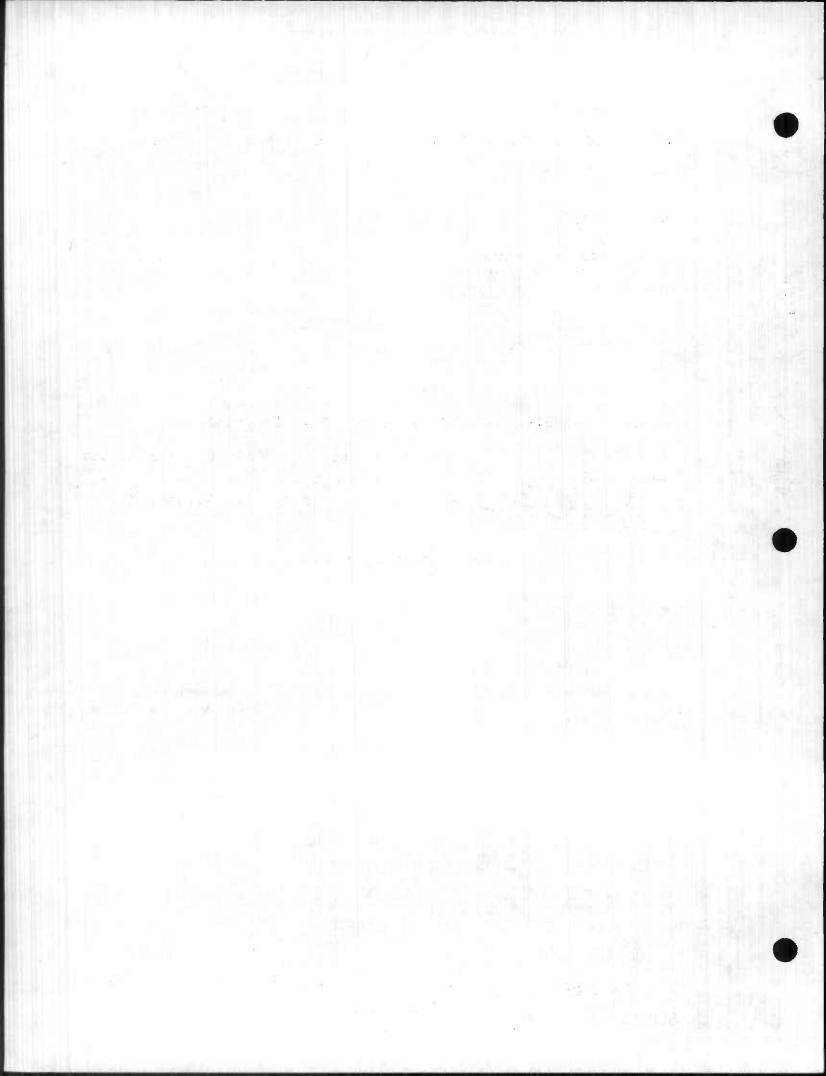
State

Registrar

31. Dete filed (Month, Day, Year)

SEP 0 5 2000

32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene

			Ce	rtificate of	Death	Re	g. No.	-	2146
Di Latara	1. Decedent's Name (First, Middle, Las	1)				2. Date of Deat Month	h Day	Year	3. Time of Death
Physician / /Medical	HARRY	LEE	ME	ISEA		Ava	20, 2	000	05-15 A
Examiner	4a Facility Name (If not institution, give				4b. City, Town, or L		4c. County		
	ER FALLSTON	GENERAL	- Itos F		FALL	2007	HAZ	LPO	20
Funeral Director	220-24-9005	7. Age (in y	rs. last birthday, Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 9/22/]	Year) 928	9. Birthpl Count Mar	ace (State or Fore
	Usual Residence of Decedent  10a. State 10b. County	100	City, Town or L	ocation				1/	d. Inaide City Lim
23a or 28a-i show unt be modified at rai Director	MD. Hari		Ony, Your of E		hite Ha	11			1 ☐ Yes 2 📉
or 2	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	hat Count	ry?
23 23	4794 Norrisvi	ille Road			21161	U.S.			The second second
at, or items 234 Executes round by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	U,S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No		ecify Yes or No- Rican, etc.)		- America k, White, e	
"natural", edical Exi	15. Decedent's Edi		16a Dece	dent's Usual Occup	ation		16h Kind of Bu		
Note that the state of the stat	(Specify only highest grad	de completed)	/Give	kind of work done DO NOT use retire	during most of work	ing		Baltimore	
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	17. Father's Name (First, Middle, Last)		lousu	omer we	18. Mother's Nam	e (First, Middle, M			COLIC
2 2 0	William	М.	Meise	90	का र	zabeth		m	home
To	19a. Informant's Name/Relationship (T			ing Address (Street			City or Town		
Important: if item 27 i any injury or other tr	Harry L. Meiser  20a. Method of Disposition  1 Burlal 2 M Cremation 3 Di  4 Donation 5 Other (Specify)  21 Signature of Funeral Service Licent	Removal from Stete	Place of Disposemetery, cre  R.rroll  2	First A osition (Name of matory or other pla Cremat 2. Name and Addre B. G. Ku	ion ss of Facility	3/21 2000 H	lampst	city or To	Maryl
/sician ledical aminer	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. A 3	eath. Do not en	>	sville, ng, such as cardiac	or respiratory arm	est,		Approximate Interval Between Onset and Deat
ing physician end e as the bunal-transit Medical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last	c	(or as a conse						
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page 2 should be det Completed by P						24a. Was a perform	n eutopsy ned?	ava	ore autopsy findir silable prior to appletion of cause death?
page Page						1 🗆 Y	s 200No	1	Yes 20000
certificate rector, pa	25. Was case referred to medicel examiner?				26. Place of Dea	th (Check only on	e)		
0 D	1 No 2 No	Hospitel: 1 Inpatient 2	ER/Outpatie	ent 3 DOA Ott	ner: 4 🗆 Nursing H	ome 5 Reside	ance 6 Othe	er (Specify	1)
al Director: After this ied in by the funerel Certification: 7	27. Manner of Death  1 Naturat 2 Accident 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year		M 1	ry at rk? Yes 2 □ No	28d. Describe ho			
led in by	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t nome, farm, st ocify)	treet, factory, office		281. Location (Si City or Town		er or Hura	r Houte Number,
To the Funeral Direction of the Medical Certi		rsician: To the best of my liner: On the basis of exam and manner stated.		nvestigation, in my o	opinion, deeth occur	red at the time, d	ete and place, a	and due to	the cause(s)
To To	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month,								
	yanshit	MLIM	DME		DOME		tuq 2	0,2	000
15	30. Name and address of person who co		tem 23e) (Type	, Print)	BEL AND	~02	21014		
	31. Date filed (Month, Day, Year)	32. Registrar's Sig							

-4.7

Certificate of Death Reg. No.	UU	2911
state of Maryland / Department of Health and Mental Hygiene	00	0011

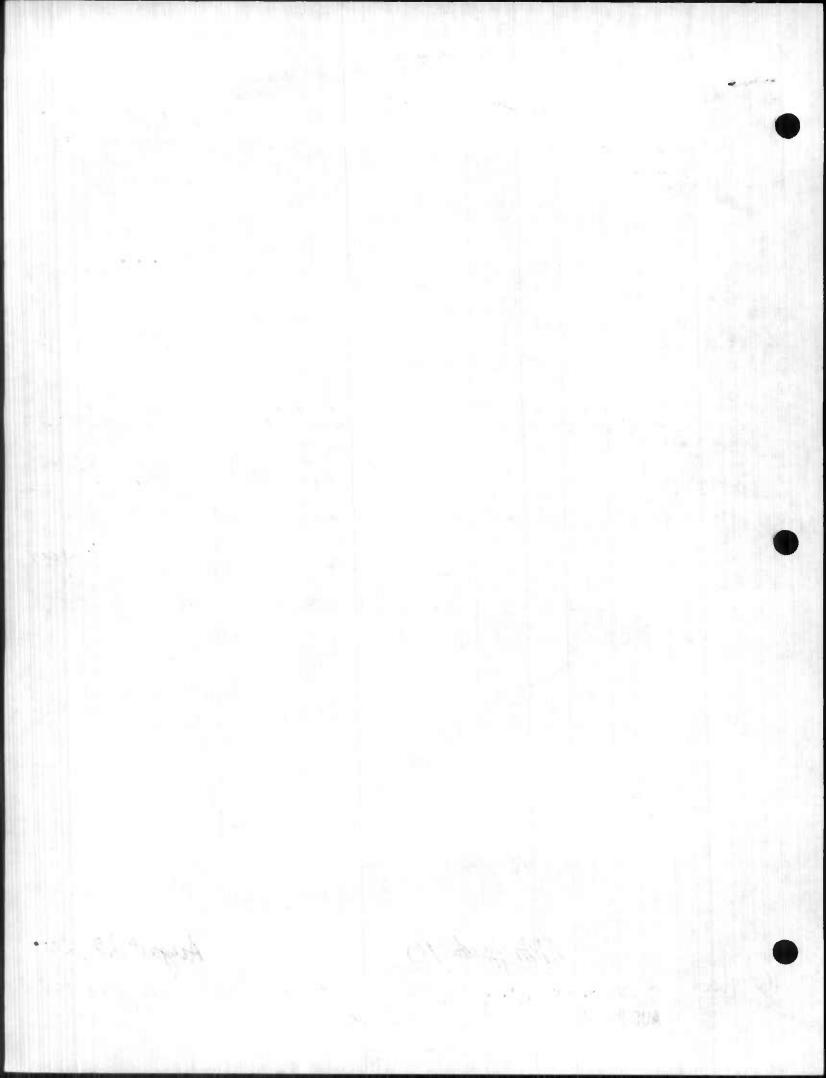
			Certificate of	Death		Reg. No.	U	23140
Dhuninian	Decedent's Name (First, Middla, Last)			24 1 -11	2. Data of De		Year	3. Tima of Death
Physician /Medical	Michael Norm				August	25°, 20		12;50 A.I
Examiner	4a Facility Nama (ff not institution, give street		500	4b. City, Town, or L	ocation of Deatl			
30	Manor Care Health Ce	7. Age (In yrs. last b	inthday) If Under 1 Yaa	Wheato			gome:	A
Funeral Director	578-58-8387 1X M		Yrs. Months Days		(Month, Da 5/25/	y. Year) 44		lace (Stata or Foreign try) h., D.C.
and **	Usual Residence of Decedant  10a. Stata  10b. County	10c. City, Tov	wn or Location				1	0d. Insida City Limits
15-0020 72 hours after death with the Maryland 72 hours after death with the Maryland 72 hours or thems 23s or 28s-f show 61st Examine must be routed at	Md. Prince Georg	ge's	Fores	stville		Table 1		1√Xas 2□No
	10e. Street and Number 2331 Seton Way	10f. Zip Coda 20747			10g. Citizan of What Country? U.S.A.			
	1 Nevar Married 2 Married 1	as Decedent Evar In U,S. med Forcas?  7 Yas 2 No Yes, Giva 63 - 67 har or Datas:	13. Was Decedent of if Yes, specify Cu		pecify Yes or No Rican, etc.)	- 14. Race Blac Specify.	k, White,	an Indian, etc. ack
5-0020 72 hours at natural, or of a ted by B	15. Decedent's Education (Specify only highest grada com	nieted) 16s	a. Decedent's Usual Occu	upation	kina	16b. Kind of Bu	sinass/Inc	dustry
T c	Elementary/Secondary (0-12)	ollege (1-4or 5+)	(Giva kind of work dona during most of working lifa. DO NOT usa retired)					
d 212 filed withi Hygiene. wher then ent, treek	12th		Laboratory			U.S. Government		
E Sab W	17. Father's Name (First, Middla, Last)  Heywood Fortune			18. Mothar's Nam	a Norma		e)	
Should the market	19a. Informant's Name/Relationship (Type, P	in land	b. Mailing Addrass (Strae				State 7im	Code
imore, N Pages 1 and nent of Health ant: If them 27 ury or other tr	Leola Norman/Sister		701 M St., N.	.W. #101,W				Coday
	20a. Mathod of Disposition 1 → Burial 2 ☐ Cramation 3 ☐ Ramov 4 ☐ Donation 5 ☐ Othar (Specify)	ol Disposition (Nama of ary, cramatory or other pi yland Vetera				20c. Location - City or Town, State Cheltenham, Md.		
Baltimoperation Page Department Important: Page any Injury of page.	21. Signature of Funaral Sarvice Licensee	2,57	22. Nama and Add H.S. Wash 4925 Bur	rass of Facility nington & croughs Av	Sons Co	.,Inc.	) . C .	20019
	23a. Part1. Enter tha disaasa, of complication shock, or heart failure. List only ona car	is that ceused the death. Do						Approximata Intarval Batween
f Vital Records, P.O. Box 68760, yelclan: The law requires that the death certificate be assected to conflicate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit of Be Completed by Physician/Medical Examiner	disaesa or condition rasulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or Injury that initiated evants rasulting in death) Last	Dua to (or as a preum Brown to the property of	a consequence of):  OCCCU  consequence of):	of the	eter	emie	7	
	Part If. Other significant conditions contribut	to death but not resulting in the underlying cause given in Part I.			23b. Did tobacco use contributs to the cause of death?			
	Circhos				1 Yes 2 No 3 Probably 4 Unknown			
	Hyperte.	usido			24a. Was	an autopsy ormed?	av co	ara autopsy findings ailabla prior to impletion of cause daath?
	Cerebn V2	scular o	ccider	+	10	Yas 2 No		Yas 2□ No
Vital  slelan: The certificate inector, pa	25. Was casa rafarred to medicel examinar?			26. Placa of Dea	th (Check only	one)		
- X 00 2	1 Yas 2 No Hospit	1 Inpatient 2 I ER/C	Sutpatient 3LI DOA			dance 6 Oth		y)
Ing P	1 abitatoral	a. Data ol Injury (Month, Day Year) 28b.	Tima of 1 28c. Injury W		28d. Dascribe	how injury occurr	red	
DIVISION C bal or Attanding P is after death. al Director: Aftert led in by the funers Certification:	2 Accidant invastigation 3 Suicide 6 Could not be datarmined 28	a. Place of injury - At homa, the building, atc. (Specify)		Yas 2 No	281. Location ( City or To	Street and Numb wn, Stata)	er or Aur	al Routa Number,
Division or To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification:		To the best of my knowledgen the basis of examination a						
the H thin 24 the F mplete	one)	nd manner stated.		nsa number		29d. Date 100		
or with the state of the state	29b. Signature and title of certifier	er-un	D 290. LICA	5211	76	8/	28	100
Va	30. Name and addrass of person who completed Karen E. McGibl			uitland.Md	. 207	46		1
State Registrar	31. Data filed (Month, Day, Year) AUG 2 8 2008	32. Registrar's Signatura	1	147				

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

00 29144

Thomas   Ellsworth   Nicol   Month August   20, 2000	State or Fore							
Thomas   Ellsworth   Nicol   August   20, 2000	rge's (State or Fore) Inside City Limit  Yes 2010 Idien,							
Funeral Director  Funeral Dire	State or Fore							
Society   Security Number   16.5 - 32 - 6553   13 M 2   F   7 Age (In yrs. lest birthdey)   10 months   10 month	State or Fore							
165-32-6553   13M 2   F   59   Yrs.   Months   Deys   Hours   Min.   Min.   March 8,1941   PA	nside City Limin   □ Yes 2√1 N  dien,							
10a. Stete   10b. County   10c. City, Town or Location   10d. fin	□Yes ÆN  dien,  ite							
Maryland Prince George's Camp Springs  10e. Street and Number  5205 Alderney Place  10g. Citizen of Whet Country?  5205 Alderney Place  11. Meritel Status  Armed Forces?  12. Wes Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispenic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Into Bleck, White, etc.  15. Decedent's Education (Specify only highest grade completes)  15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)  16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)  National Gov Properties  17. Father's Neme (First, Middle, Last)  18. Mother's Neme (First, Middle, Maiden Surneme) Anna Adams  19e. Informent'a Neme/Reletionship (Type, Print)  19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code Brenda Nicol (Wife)  5205 Alderney Place Camp Springs, Maryla	□Yes ÆN  dien,  ite							
11. Meritel Status	dien,							
11. Meritel Status   12. Wes Decedent Ever in U.S.   13. Was Decedent of Hispenic Origin? (Specify Yes or No-Married Origin? (Specify Cuban, Mexican, Puerto Rican, etc.)	nite							
12. Wes Decedent Ever in U.S. Armed Forces?   1961	nite							
Specify: Who   Specify: Specify: Specify: Who   Specify: Specify: Who   Specify: Specify: Specify: Who   Specify: S	nite							
15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondery (0-12) 12 +2 Building Engineer  18. Mother's Neme (First, Middle, Last) Ellsworth Nicol  19e. Informent'a Neme/Reletionship (Type, Print) Brenda Nicol (Wife)  16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) National Gov Properties  18. Mother's Neme (First, Middle, Maiden Sumeme) Anna Adams  19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code Brenda Nicol (Wife)  5205 Alderney Place Camp Springs, Maryla								
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Brenda Nicol (Wife) 5205 Alderney Place Camp Springs, Maryla	e)							
cemetery, cremetory or other piece) AllCIIST 21								
4 Donation 5 Other (Specify)  Lee Crematory  2000 Clinton, Mar	yland							
21. Signature of Funerel Service Licensee 22. Name end Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton,	, MD 20							
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line.	roximate rvel Between							
hysician snock, or heert feilure. List only one ceuse on eech line.	et and Death							
/Medical Immediate Ceuse (Final	ura							
disease or condition resulting in death)  e. Head and Neck Cancer  Due to (or es e consequence of):	700							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the infitteded events resulting in death) Last  Due to (or es e consequence of):  Due to (or es e consequence of):  Due to (or es e consequence of):								
Tany, leading to immediate cause. Enter Underlying Ceuse (Disease or injury to the infilted events resulting in death) Last  Due to (or es e consequence of):	Sequentially list conditions, Due to (or es e consequence of): if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury							
thet initieted events resulting in death) Last  Due to (or es e consequence of):								
thet initiated events resulting in death) Last  Due to (or es e consequence of):    Due to (or es e consequence of):	cause of dea							
Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.  23b. Did tobacco use contribute to the								
24e Wes an autonsy 24b. Were e								
	utopsy finding le prior to							
24e. Wes an autopsy performed?  24b. Were an avelable complet of death  1 Yes 2 No 1 Yes	tion of cause h?							
1 Yes 2 No 1 Yes	N/ s 2□ No							
25. Wes case referred to medical examiner?  Hospitel:  Other:								
25. Wes case referred to medical examiner?  1  Yes 2 No  26. Place of Deeth (Check only one)  Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
27. Menner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  28a. Dete of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No  28b. Linjury et Work? 1 Yes 2 No  28c. Injury et Work? 1 Yes 2 No  28d. Describe how injury occurred  28d. Describe how injury	n (Street and Number or Rural Route Number, Town, State)							
29e. Certifier (Check only one)								
end menner steted.  29b. Signeture end title of certifier  29c. License number  29d. Dete signed (Month, Day,	Voes							
29b. Signeture end title of certifier  29c. License number  29d. Dete signed (Month, Day,	9							
D46246 August 22	Hugust dd, door							
290. Signeture and title of certifier  290. Signeture and title of certifier  290. Determined (Month, Day, Year)  30. Name and address of person who completed course of deeth (Item 23e) (Type, Print)  Ashraf M. Meelu, M.D. 10 St. Patrick Drive Suite #105 Waldorf, Maryland (Month, Day, Year)  31. Detailed (Month, Day, Year)  32. Begistrer's Signeture								
Ashraf M. Meelu, M.D. 10 St Patrick Drive Suite #105 Waldorf, Maryla								
State 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture	and 20							



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** NAYANOGMOH 17-18 TAMBA AUGUST 2000 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not Institution, give street end number) 4c. County of Death Examiner Silver Spring mortgonot! HOSPITA HOUY CROSS 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** 1 XM 2 ☐ F Monthe Deys Hours Sierra Leone 0294609 Yrs. 69 Nov. 11, 1930 Director Usual Residence of Deceden 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Director Md. Rockville Montamery 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? r than "natural", or flams 23e or the Medical Examiner must be a 12630 Viers Mill Road 20853 Sierra Leone, West Afrid Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Agriculture 12th 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be h and Mental i Ghassy Jaima Fagbon Nyandemoh 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 an Department of Health and Important; if hen 27 is m any injury or other traun once. Finda Nyandemoh / Daughter 12630 Viers Mill Rd. Rockville, Md. 20853 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sierra Leone Kiffy Road Cemetery 9-5-00 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Capitol Mortuary, Inc. a 1425 Maryland Ave., NE Wash., DC 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** APTERIOSCURPATIC CAMDIOUNSOUR DISENSE /Medical Immediate Cause (Final disease or conditio resulting in death) Examine Due to (or as a consequence of) Examiner and -tran Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) physician a s the burial-Physician/Medical Due to (or as a consequence of): 50 for use as signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown SETZULE DISCREPA by 24b. Were autopsy findings available prior to completion of ceuse of death? should should 24a. Was an autopsy Completed page 2 s 1 Yes 2DING 1 □ Yes 2 No director, 25. Was case referred to medicel exeminer? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Certification: To After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation filled in by the f 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es etated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Chee within 2 29d. Date signed (Month, Day, Year) 29b. Sign and title of certifier 29c. License number OME) DI5236 AUTUST 18, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADOCKUNUT PIET, ADORANCE, MO 20859 COOL I. MARGOLIS, MD 11125 3. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 2 4 2000 State

72 hours shar

should be

that the death certificate be executed

The law requires

or Attending Physician:

10

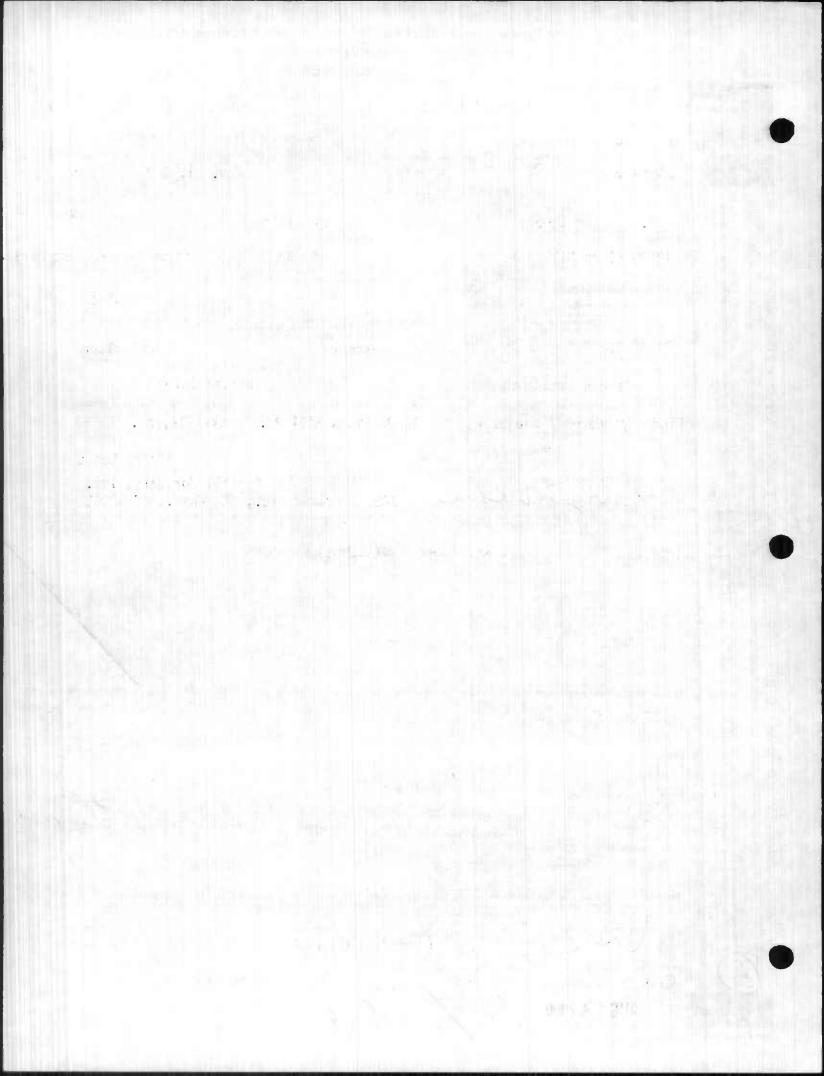
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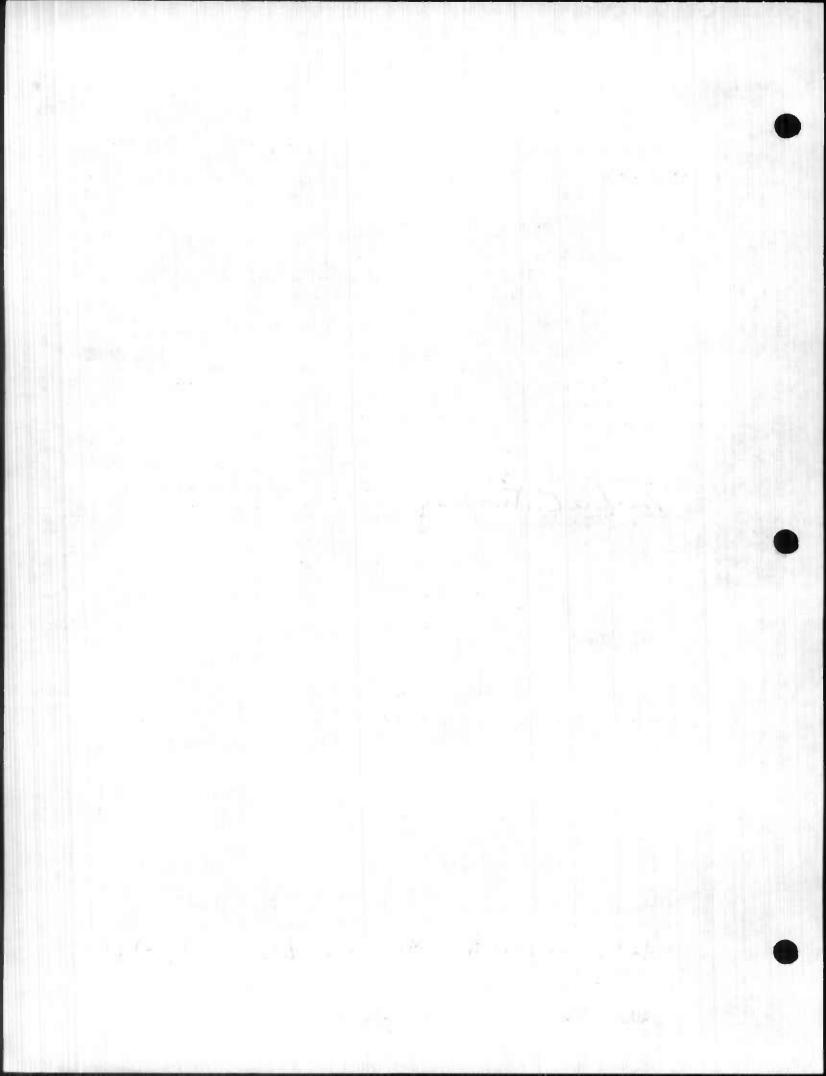
Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0020

Registrar



-	Decedent's Name (First, Middle, Last)	State of Marylar	Certifica			2. Dete of De	Reg. No.	0 2	3. Time of Death
Physician /Medical	SARAH E.	O'NEAL				AUG.	26, 20	OO	2:38 PM
Examiner	4a Facility Name (If not institution, give				4b. City, Town, or				
W	HOLY CROSS HOSPIT  5. Social Security Number  6. Security Number		(act hirthday) If Unc	der 1 Year	SILVER S			GOMER	
Funeral Director		7. Age (m y/s.	3 Yrs. Month			. (Month, D	oy, Year) 10, 1926	WIS	laca (Stete or Foreign try)
Mount	10a. State 10b. County	10c. Cit	ty, Town or Location					10	Dd. Inside City Limits
th with the Maryler 23e or 28e-f show the rectines	MD MONTGON	IERY SI	LVER SPRIN	G					1 Yes 2 No
or 28s-f s	10e. Street and Number		10f. 2	Zip Code			10g. Citizen of V		try?
ath w	807 SILVER SPRIM			20910			u. s		
d within 72 hours effer death with the Maryland giene. The hardrail or farms 23a or 28a-f ahow the Maryland and the contract of the Maryland and the Maryland and the Maryland and Maryland	11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:		cedent of I becify Cub 2 X No	Hispanic Origin? (span, Mexican, Puer Specify:	Specify Yes or Note Rican, etc.)	o- 14. Rac Blac Specify	a - America k, White, e	etc.
natural.	15. Decedent's Educ (Specify only highest grade		16a. Decedent's Us	sual Occup	pation during most of wo	orkina	16b. Kind of Bu		
ed within 72 ho ygiene. or than "naturi ft, me Wocall	Elementery/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	use retire	od)				
Hiled w	12TH GRADE 17. Fether's Name (First, Middle, Last)		FOOD SER	VICE		ma /First Middle	SOUTHER Maiden Sumem		IER
Saby W	WILLIE HARVEY EDW	ARDS				LLIE BEA		18)	
2 should and Men and M	19e. Informant's Neme/Relationship (Ty		19b. Mailing Addre	ss (Street				State, Zip	Code)
CENL	JACQUELINE WILSON		135 - 11T	H ST.	., N. E.	WASH.,	DC 2000	2	
of Heal	20a. Method of Disposition		Plece of Disposition (A cametery, cremetory o	leme of r other ple	ice)	Date	20c. Location -	City or To	wn, State
Pages nent of l	1 N Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	ENWOOD CEN			9-2-00	WASHING	STON,	DC
permit. Pages t at Department of Hear Important: if Itam: any Injury or othe pinca.	21. Signature of Europeal Service License	Pinckn			ess of Facility SPANGLER ST., N.			0002	
-	23a. Part1. Enter the disease, or compli shock, or heart faiture. List only or	cations that caused the deat	th. Donot enter the m	ode of dyi	ng, such as cardia	c or respiratory	arrest,	0002	Approximate tntervet Between
Physician /Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death)	INFECTED DE	CUBETUS UL or as a consequence o		SACRAL			1	Onset and Death  1 DAY
neit neit	_ t	FLEXION CON						t	4 yrs.
physician and strength but sthe burist-transit	Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	STATUS POST		VASC	ULAR ACCI	IDENT		t	4 YRS.
et the death certificate be axed by the attending physician efached for use as the burief Physician/Medical E	resulting In death) Last		or as a consequenca o	.,.					
0 0 0	Pert II. Other significant conditions con	tributing to death but not res	ulting In the underlying	g cause gi	ven in Part I.	23b. Did	tobacco use co	ntributs to	the cause of death
requires that the deseen signed by the a hould be detached feeled by Physic	DILATED CARDIO	MYOPATHY, PAR	KINSON'S D	ISEA	SE	10	Yss 2 No	3 Prob	pably 4 Unknow
aw requi	ADVANCED AGE						s en autopsy ormed?	ava	ere autopsy findings allable prior to inpletion of cause death?
or attending Physician: The law requires the star deeth.  Director: After this certificate has been signed in by the funeral director, page 2 should be estification: To Be Completed by						10	Yes 2 No	1	Yes 2□ No
Physician: The this certificate ral director, pag	25. Wes case referred to medical examiner?	ospital:		Oil	her:	ath (Check only			
T dig	1 Yes 2 XNo 27. Menner of Death	28a. Date of Injury	ER/Outpatient 3 28b. Time of	DON	4 Li Nursing	_	how Injury occur		)
Attending P or death.  actor: After the funerity the funerity the funerity the funerity the funerity that the funerity the funerity that t	1X Neturel 5 ☐ Pending investigation	(Month, Dey Year)	Injury	28c. Inju Wo 1	rk? ]Yes 2□No	200.000.00	mon mjery occan		
or A Direction by	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifical Control of the Control of	ome, farm, street, factify)	ory, office			(Street and Numb own, State)	er or Rura	l Route Number,
he Hospital in 24 hours he Funeral I pletely filled edical Ce	29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	ician: To the best of my kno er: On the basis of exemine end menner stated.	wledge, death occurre tion and/or investigation	ed at the ti on, in my o	me, date and plec opinion, deeth occ	e, end due to the urred at the time	ceuse(s) and ma , date and ptace,	nner as st and due to	ated. the cause(s)
To the comple	29b. Signeture and title of certifier	A	2	9c. Licens	se number		29d. Date signe	d (Month, I	Day, Year)
F 3 F 8	1 And 1 M	Melt	CM	CT	7361		8/2=	+10	117
(1)	30. Name and address of person who co	mpleted cause of death (Item	n 23a) (Type Print)	900	000		-1-	10	U
	ARVIND MEHTA, M. 1		IMORE AVE.	co	LLEGE PAI	RK. MD 2	0740		
State	31. Date filed (Month, Day, Year)	32. Registrar's Signa				, 1.10			
Registrar	ALIG 3 0 2000	mercan	354						



State of Maryland / Department of Health and Mental Hygiene

nd Mental Hygiene	00	291	1.7
Reg. No.		Las a	1

		Certificat	e of Death	P	Reg. No.	
	est)			2. Date of Dea	ıth	3. Time of Death
12/11 A 1/1)	H. OTEY	SR.				
An Challing blome /// not broken the of		TES (ME) IN	4b. City, Town, or L	ocation of Death	4c. County of I	Death
SOUTHERN MARYLAN	D HOSPITAL		CLINTON		PRINCE	
	- T	Months	Days Hours Min.	(Month, Day	, Year) 9.	Birthplace (State or Foreign Country)
227-18-0800	74	113.		JAN. 6,	1926 OK	ANGÉ COUNTY, V
10a. Stata 10b. County	10c. C	ity, Town or Location				10d. Inside City Limits
MD PRINCE G	EORGE U	PPER MARLBOI	20			1XIYas 2□No
10e. Street and Number		10f. Zij	Code		10g. Citizen of Wha	it Country?
8418 GRANDHAVEN	AVENUE		20772	1913	II. S. A.	
11. Marital Status			dant of Hispanic Origin? (Sp	pecify Yes or No-	14. Race -	American Indian,
1 Nevar Married 2 Married		743		ribari, etc.)		wille, etc.
			Specify.		эрвену.	BLACK
15. Decedent's E		(Give kind of wo	rk done during most of work	king	16b. Kind of Busin	ess/industry
Elementary/Secondary (0-12)	College (1-4or 5+)				II C D	OCT DEFICE
17 Fathar's Name /First Middle Lest	1	PUSTAL CI		a (First Middle		USI UITICE
DIIFIIC OTF						
-		10h Malling Address				ate Zin Code)
						10, 210 0000)
20a. Method of Disposition	JK. 20b.	Place of Disposition (Ne	me of	Date Date	20c. Location - Cit	y or Town, Steta
1 Burial 2 ☐ Cremation 3 ☐	Removal from State (y)			9/5/00	CHELTENH	IAM, MD
21. Signature of Funerel Service Lice	nsee D 6	A second				
230 Parts Enter the disease or com	professions that could be don					20002 Approximate
shock, or heart failure. List only	one cause on each lina.	) or amar tria mo	or dying, sacri as our day	or respiratory at	ruot,	Intarval Between Onset and Death
Immediate Cause (Final	<i>i</i> 23 .	. 0				
disease or condition resulting in death)	0.			9		
	Due to	(or as a consequence of)	/ ^ -	21 4		
Commentally that are distance.			ian itc	CIUENT		1
if any, teading to immedieta cause. Enter Underlying	500 10	or as a someoquemos siy				
Cause (Disease or injury that initiated evants	c. Dua to (	or as a consequence of):				
rasulting in death) Last						
	d					1
Part II. Other algnificant conditions of	contributing to death but not re	sulting in the underlying	cause given in Part t.	23b. Did t	obacco use contri	buts to the cause of death?
Charania	00 -1	(2)		101	Yes 2 No 3	☐ Probably 4☐ Unknown
C1 10 853 C	) lemaj	Tarrare				
Condid	· A · · · · dt	Som Son C		24a. Was a perfor		24b. Ware autopsy findings available prior to
	- /			- XX 48		completion of cause of death?
Hyber	tensive t	east of	gense.	1 D Y	es 2000	1 ☐ Yes 2 ☐ No
25. Was case referred to medical				th (Check only o	ne)	
	Hospitat: 12 Inpatient 2[	☐ ER/Outpatient 3☐ D	OA Other: 4 Nursing H	oma 5 🗆 Resid	iance 6 Other	(Specify)
27. Mannar of Death	28a. Date of Injury (Month, Dey Year)			28d. Describe h	now injury occurred	
2 Accident investigatio		М	1 ☐ Yes 2 ☐ No			
4 Homicide datarmined	Zoe. Place of injury - At	homa, farm, street, factor	y, office			or Rural Route Number,
	niner: On the basis of examin					
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exer	and mannar stated.					
29a. Certiflier 1 Certifying Ph (Check only 2 Medical Exar one) 1 Medical Exar 29b. Signature and title of certifler	and mannar stated.		c. License number		29d. Date signed (	Month, Dey, Year)
29b. Signature and title of certifier	MC	)	D 28035		08-0	28-00
29b. Signature and title of certifier	MC	)	D 28035		08-0	28-00
	MC	)	D 28035		08-0	28-00
	ROLAND  4a Facility Nama (If not institution, gives to be a county Number 229-18-0800  Usual Residence of Decedent 10a. Stata 10b. County MD PRINCE Grant 10a. Stata 10b. County MD PRINCE Grant 10a. Stata 10b. County MD PRINCE Grant 11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Expectify only highest grant 15. Decedent's Experity onl	ROLAND  4a Facility Nama (If not institution, give street and number)  SOUTHERN MARYLAND HOSPITAL  5. Social Security Number  229-18-0800  WM 2 F  7. Aga (In yrs  229-18-0800  WM 2 F  7. Aga (In yrs  229-18-0800  WM 2 F  7. Aga (In yrs  8. Aga (In yrs  9. Aga (In yrs  10. Color  10.	ROLAND  H. OTEY, SR.  4a Facility Nama (If not institution, give street and number)  SOUTHERN MARYLAND HOSPITAL  5. Social Security Number  6. Sex  129 - 18 - 0800  Usual Residence of Decedent  10a. State  10b. County  MD  PRINCE GEORGE  10c. City, Town or Location  MPRINCE GEORGE  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Near and Forces?  11. Martial Status  11. Near or Dates:  11. Martial Status  12. Was Decedent Ever in U.S.  11. Martial Status  12. Was Decedent Ever in U.S.  13. Wis Decedent Status  14. Was Decedent Ever in U.S.  14. Was Decedent Status  15. Decedents Education  (Specify only highest grade completed)  16. Decedents Usus  (Specify only highest grade completed)  17. Father's Name (First, Middle, Last)  RUFUS  19. Informant's Name/Relationship (Type, Print)  19. Mailing Addrast  ROLAND H. OTEY  19. Informant's Name/Relationship (Type, Print)  19. Mailing Addrast  15. 11. PeAst  ROLAND H. OTEY  19. Informant's Name/Relationship (Type, Print)  19. Mailing Addrast  15. 11. PeAst  ROLAND H. OTEY  19. Informant's Name/Relationship (Type, Print)  19. Mailing Addrast  15. 11. PeAst  ROLAND H. OTEY  19. Informant's Name/Relationship (Type, Print)  19. Mailing Addrast  15. 11. PeAst  ROLAND H. OTEY  19. Informant's Name/Relationship (Type, Print)  19. Mailing Addrast  15. 11. PeAst   ROLAND  4e Facility Niama (If not institution, givs street and number)  SOUTHERN MARYLAND HOSPITAL  5. Social Security Number  229-18-0800  What is a consequence of Decadert  10e. State  10e. State  10e. County  MD  PRINCE GEORGE  10c. City, Town or Location  WPPR MARLBORO  10c. Zity Code  20772  10e. Street and Number  8418 GRANDHAVEN AVENUE  11. Martial Status  12. Was Decadent Ever in U.S.  Armed Forces?  1943  Wildowed 4 Divorced  15. Decadent's Usual Occupation  (Speedly only highest grade completed)  16. Decadent's Usual Occupation  (Speedly only highest grade completed)  17. Fathar's Name(First, Middle, Last)  RUFUS  19e. Informant's Name(First, Middle, Last)  RUFUS  19e. Informant's Name(First, Middle, Last)  RUFUS  19e. Mailing Addrass (Street and Number or Ru  17th GRADE  19e. Mailing Addrass (Street and Number or Ru  17th GRADE  19e. Mailing Addrass (Street and Number or Ru  17th GRADE  19e. Mailing Addrass (Street and Number or Ru  17th GRADE  19e. Mailing Addrass (Street and Number or Ru  17th GRADE  19e. Mailing Addrass (Street and Number or Ru  17th GRADE  19e. Mailing Addrass (Street and Number or Ru  17th GRADE  19e. Mailing Addrass (Street and Number or Ru  17th GRADE  19e. Mailing Addrass (Street and Number or Ru  19e. Mailing Addrass (Street and Numbe	ROLAND  H. OTEY, SR.  AUG.  4a Facility Name (Incrinstitution, p/vs street and number)  SOUTHERN MARYLAND HOSPITAL  5. Social Security Number  5. Social Security Number  7. Aga (In yrs. leaf birtheay)  Whorths Deys Hours Min.  7. Aga (In yrs. leaf birtheay)  Whorths Deys Hours Min.  7. Aga (In yrs. leaf birtheay)  Whorths Deys Hours Min.  7. Aga (In yrs. leaf birtheay)  Whorths Deys Hours Min.  7. Aga (In yrs. leaf birtheay)  Whorths Deys Hours Min.  7. Aga (In yrs. leaf birtheay)  Whorths Deys Hours Min.  8. Date of Brit Minnth Deys I Hours Min.  8. Date of Brit Minnth Deys I Hours Min.  8. Date of Brit Minnth Deys I Hours Minn.  8. Date of Brit Minnth Deys I Hours Minn.  8. Date of Brit Minnth Deys I Hours Minn.  9. Date of Brit Minnth Deys I Hours Minnth Deys Minnth Deys I Hours Minn.  9. Date of Brit Minnthhor Deys I Hours Minnthhory  10c. City, Town or Location  10c. C	ROLAND H.  TEV, SR.  4a Facility Name (if not institution, pins stored and number)  4b. City, Town, or Location of Death ALG.  5. Social Security Number  29-18-0800  TV III The Prince of Death of Death ALG.  5. Social Security Number  29-18-0800  TV III The Prince of Death of Death ALG.  5. Social Security Number  29-18-0800  TV III The Prince of Death of Death Inc.  10c. City, Town or Location  PRINCE GEORGE  UPPER MARLBORO  10c. City, Town or Location  UPPER MARLBORO  10c. City Town or Location	

DHMH 16 Ray 6/95

Mary of the state 
an	1. Decedent's Neme (First, Middle, Last)								2. Date of I Month	Death Day	y	Year	3. Time	of Deeth
, al	John Anthony Par								Augus	-		000	5:4	0 A.M.
ici	a Fecility Name (If not institution, give							11	ocation of De	ath 4c.		of Deeth		
	3808 Oglethorpe Social Security Number 6.5		(In yrs. iast	hidhday)	f Under 1 Y		Hyatt			lirth		nce (		
		WYM OFF	45			ays	Hours	Min.	8. Dete of E (Month, I Sept. 3	30, 19	954	Okla	homa	or Foreign
	0a. State 10b. County		10c. City, To	own or Locati	ion		144					10	d. Inside (	City Limits
क्	Maryland Prince	George's	Hyat	tville									1 ☐XYe	s 2 No
Director	De. Street and Number				10f. Zip Co	de				10g. Citi	izen of V	What Count	ry?	
	3808 Ogelthorpe				2078					U.S.				
	1. Meritel Status  1 Never Married 2 Married	12. Wes Decedent Ev Armed Forces? 1 Yes 22No			s Decedent es, specify Yes 2 🔀		spante Orig n, Mexicen Specify:	gin? (Spi , Puerto	ecify Yes or t Rican, etc.)	No-		e - America ck, White, e	itc.	
λα p.	3 Widowed 4 Divorced	Year or Detes:	1 4	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	#- !!\ O		A!			top K		W	hite	
Completed	15. Decedent's E (Specify only highest gri		11	6a. Decedent (Give kind life. DO	d of work a NOT use r	occupat done du retired)	uring most	of work	ing	16D, KI	ing of Bu	usiness/Ind	ustry	
	Elementary/Secondery (0-12)	College (1-4or 5+	)	Plumb						Pr	ivat	e Ind	ustr	v
	7. Fether's Neme (First, Middle, Last	)					18. Mothe	r's Name	First, Midd					
0 1	Thomas E. Paris						Mary	Ann	Prih	ode				
19	9e. Informent's Neme/Relationship (	(Type, Print)	1	19b. Meiling A	Address (S	treet e	-				or Town,	State, Zip	Code)	
D	iana Paris - Wife	e	3	808 Og	elthc	orpe	Str	eet,	Hyatt	svil	1e,	MD 2	0782	
20	Da. Method of Disposition		20b. Plece	e of Disposition	on (Neme	of r place	a)	t	Dete	20c. Lo	ocation -	City or Tox	wn, State	
	1 ☑ Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			Linco				19	/1/00	Brei	ntwo	od, M	m	
2	1. Signature of Fune PAService Lick	_	1016	22. N	ame and A	ddress	s of Facility	V			IILWO	ou, ii	<u> </u>	
	11 1110	1 11												
		1 (1)	+				neral	Hon	ne, P.A			- M	20.	701
2:	3a. Part1. Enter the displication com	phone that caused a	1	473	9 Bal	Ltin	neral nore	Hon	ue, Hy	atts	vill	e, MD	Approxim	781
2	3a. Part1. Enter the discussive com- shock, or heart failure. List only	pau () P polications that caused to one cause on each line	1	473	9 Bal	Ltin	neral nore	Hon	ue, Hy	atts	vill			ate etween
In	m <i>m</i> ediate Ceuse (Finet liseese or condition	polications that caused a one cause on each line	1	473 Do not enter the	9 Bal	Ltin f dying	neral nore	Aven	or respiretory	arrest,			Approximation	ate etween
l In di	mmediate Ceuse (Finet	COMBI	NED I	473 Do not enter the	he mode o	Ltin f dying	neral nore	Aven	or respiretory	arrest,			Approximation	ate etween
l In di	m <i>m</i> ediate Ceuse (Finet liseese or condition	COMBI	NED I	473 Do not enter the	he mode o	Ltin f dying	neral nore	Aven	or respiretory	arrest,			Approximation	ate etween
l In di re	mmediate Ceuse (Finel liseese or condition esulting in death)	combi	NED I	473 Do not enter the	39 Ba] the mode of AND note of):	Ltin f dying	neral nore	Aven	or respiretory	arrest,			Approximation	ate etween
Examiner and in the second sec	mmediate Ceuse (Finet lisease or condition esulting in death)  Sequentially list conditions, any, leeding to immediate ause. Enter Underlying ause (Disease or Injury	combi	NED I	473 Do not enter to	39 Ba] the mode of AND note of):	Ltin f dying	neral nore	Aven	or respiretory	arrest,			Approximation	ate etween
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Indice of Livering Particular Cramman Particular Partic	issesse or condition esulting in death)  Sequentially list conditions, any, leeding to immediate ause. Enter Underlying lause (Disease or Injury net initiated events esulting in deeth) Last  ATTIL Other eignificant conditions of HYPERTENSIVE  DISEASE  5. Was case referred to medical examiner?	b	NED I	DRUG se consequer a consequer g in the unde	AND nce of): nca of): arrying caus	ALC	neral nore n such es COHO n in Pert f. ASCUI	Hom Aven cardiec of L II	23b. Di 24e. W. pe	rattsv arrest,  CATI  d tobacco  Yee 2  yone)	ON  Dues con  C No  Psy	24b. We corror of o	Approxim Intervat Bio Onset and the cause the cause with the cause with the cause the cause of t	of death?  white of death?
Indice of the second se	mmediate Ceuse (Finet issesse or condition esulting in death)  Sequentially list conditions, any, leeding to immediate ause. Enter Underlying ause (Disease or Injury net initiated events esulting in death) Last  art II. Other eignificant conditions of HYPERTENSIVE  DISEASE  5. Was case referred to medical examiner? 11327es 2 □ No 7. Menner of Death	b	NED I pue to (or as use to (or	DRUG se consequer a consequer a consequer TIC C	AND nce of): nce of): artying caus ARDI  3□ DOA A   28c.	ALC OVF	neral nore n such es COHO  an in Pert f. ASCUI	Hom Aven cardiec of L II	23b. Di 24e. Wy	rattsvariest,  CATI  d tobacco  Yee 2  es an autopromed?  Pes 2  y one)	ON  Dues con  Don  Don  Don  Don  Don  Don  Don	24b. We corror of c	Approxim Intervat Bio Onset and the cause the cause with the cause with the cause the cause of t	of death?  Findings  To to cause
To Be Completed by Physician/Medical Examiner	mmediate Ceuse (Finet issess or condition esulting in death)  bequentially list conditions, any, leeding to immediate ause. Enter Underlying ause (Disease or Injury net initiated events esulting in death) Last  art II. Other eignificant conditions of HYPERTENSIVE  DISEASE  5. Was case referred to medical examiner?  1 1 Yes 2 No  7. Menner of Death  1 Netural 5 Pending	combination of the contributing to death but ARTERIOSC  Hospital: 1   Inpatient   28e. Detection injury   FOUND   1997	NED In the to (or as the to (o	DRUG  a e consequer  a consequer  g in the unde  TIC C	AND nce of): nce of): artying caus ARDI  3□ DOA A   28c.	ALC Other Injury	neral nore n such es COHO  an in Pert f. ASCUI	Hom Aven cardiec of L III	23b. Di 24e. Wi pe  h (Check onlime 5 □ Re 28d. Describ	rattsvariest,  CATI  datobacco  Yee 2  es an autor  rformed?  es 2  y one)  sidenca  e how injur	ON  Dues con  Du	24b. We corror of c	Approxim Intervat Bio Onset and the cause the cause with the cause with the cause the cause of t	of death?  white of death?
10 de Compreted by Physiciary Medical Examiner	issess or condition esulting in death)  Sequentially list conditions, any, leeding to immediate ause. Enter Underlying Jause (Disease or Injury net initiated events esulting in death) Last  art II. Other eignificant conditions of the conditions o	c. Di  d. Contributing to death but  ARTERIOSC  Hospital: 1   Inpatient  288. Dete of Injury FOUND: 8-27-0	NED In the to (or as the to (o	DRUG se consequer a consequer a consequer TIC C	AND nce of): nce of): artying caus ARDI  JOA A 28c.	ALC Other Injury Work 1   Y	neral nore n such es COHO  COHO  26. Place H 4 Nu	Hom Aven cardiec of L III	23b. Di  24e. Wi pe  th (Check only me 5 □ Re 28d. Describ	rattsvariest,  CATI  del tobacco  Yee 2  es an autor  rformed?  Ses 2  y one)  sidenca e how injui	ON  Dues con  Dues con  No  Solution  No  No  No  No  No  No  No  No  No	24b. We ave corror of correct (Specify red	the cause the ca	of death?  Onlings To cause  No
To Be Completed by Physician/Medical Examiner	mmediate Ceuse (Finet lisease or condition esulting in death)  Sequentially list conditions, any, leeding to immediate ause. Enter Underlying ause (Disease or Injury net initiated events esulting in death) Last  and II. Other eignificant conditions of the conditio	combination of the contributing to death but the contribution of t	NED In the to (or as the to (o	DRUG  s e consequer  a consequer  a consequer  b TIC C.  Coutpetient  b. Time of  F. County  5 : 30  o, farm, street	AND nce of): nce of): arrying caus ARDI  ARDI  JOA A 28c. A fectory, of	ALC Othe Injury Work Injury To Y	neral nore n such es COHO  26. Place et ? es 201	Hom Aven cardiec of L III	23b. Di 24e. W. pe 1/Check online 5 □ Re 28d. Describ	d tobacco  Yee 2  y one)  Isidenca he how injur  NKNOU  (Street erfown, Stete	ON  Dues con  No  Sylvania Number  No  MN  MN  MN  MN  MN  MN  MN  MN  MN	24b. We ava cor of cor of a co	the cause the cause of the caus	of death?
Certification: To Be Completed by Physician/Medical Examiner	issess or condition esculting in death)  Gequentially list conditions, any, leeding to immediate ause. Enter Underlying ause (Disease or Injury net initiated events esulting in deeth) Last  and II. Other eignificant conditions of the conditions o	combination of the contributing to death but the contribution of t	NED In the to (or as the to (o	DRUG  se consequer  a consequer  a consequer  by in the under  Courted the consequer  Courted the courted the courted the consequer  Courted the courte	AND nce of): nce of): arying caus ARDI  ARDI  JOA A 28c. A fectory, or SIDE	ALC Other Other Other NCE	neral nore n, such es COHO  26. Place  26. Place  26. Place 27 (es 2 21	Hom Aven cardiec of L III	23b. Di  24e. Wi pe  1 Check onl  28f. Location City or 1  28f. Location City or 1  28f. and due to the control of the control City or 1  28f. document of the control of t	rattsv arrest,  CATI  dd tobacco  Yee 2  es an autor fromed?  Ves 2  y one) sidenca he how injun NKNOU  (Street er frown, Siele  (ATTS) he cause(s)	ON  Dues con  Dues con  No  SVIL  SVIL  Only  On	24b. We ava corred  24b. We ava corred  24c. W	the cause with the ca	of death?

August 27, 2000

O.C.M.E.

erson who completed cause of death (Item 23e) (Type, Print) 30. Name and address of

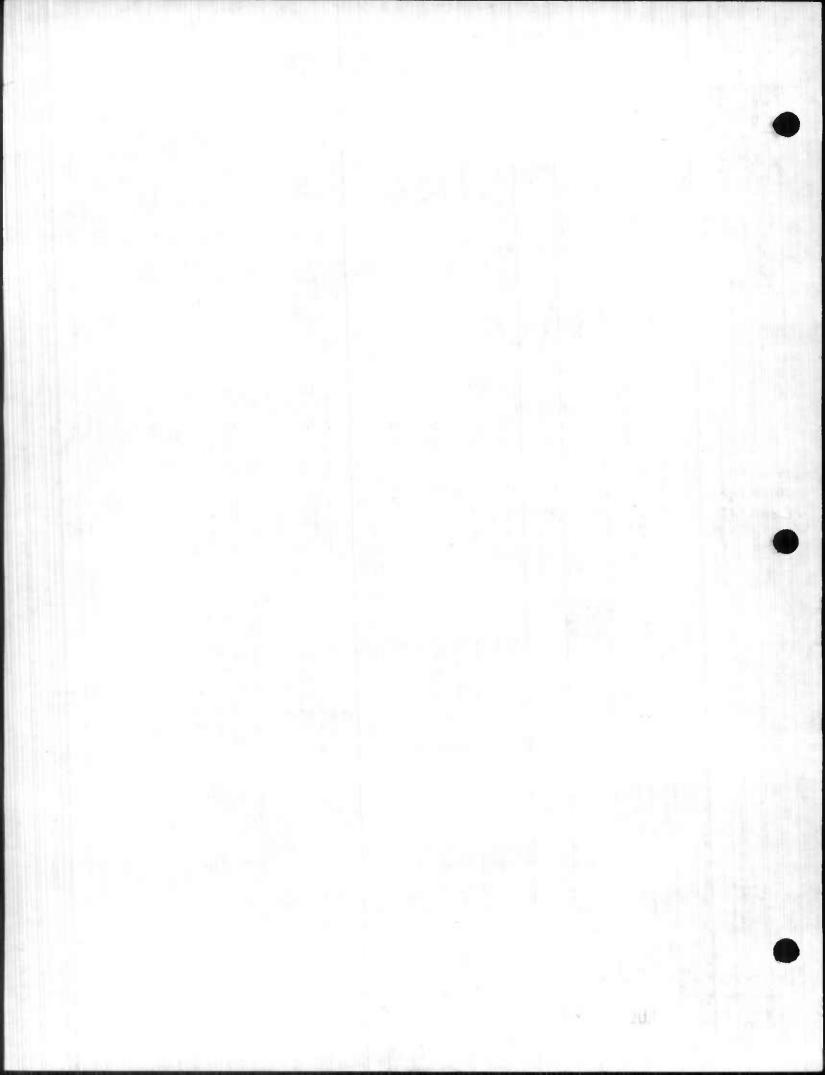
NIPPUL M. ) 111 Penn Street, Baltimore, Maryland 21201

31. Dete filed (Month, Dey, Year) AUG 2 9 2000 32. Registrar's Signeture

DHMH 16 Rev 6/95

State

Registrar



			Cei	rtificate o	f Death	1		Reg. No.		
1. Decedent's Name (First, Middle	e, Last)		=	F. The Control			2. Date of De		Yaar	3. Time of I
Walter Francis	Powell						HIGHS	t 27	2000	8:1
4a Facility Name (If not institution	n, give street and nur	m <i>ber)</i>			4b. City, To	own, or Loc	ation of Deet	th 4c. Count	ty of Death	
Doctor's Commun				Milledge 4 Ver	Lanha er I If Under					orge's
5. Social Security Number 578-22-2151	6. Sex 180 M 2□ F	7. Age (In yrs.	iast birthday) Yrs.	Months Day		Min.	8. Dete of Bir (Month, Di	nth ay, Year)	9. Birthpl	aca (State or try)
Usual Residence of Decedent		77					UCT. I	14, 1922	Ohi	.0
10a. Stete 10b. County		10c. Cit	ty, Town or Lo	ocation					10	Dd. Inside City
Maryland Princ	e George'	s I	anham	- Seabr	ook					1½ Yes
10e. Street and Number	000180		3011110111	10f. Zip Code				10g. Citizen of	What Count	try?
6907 Presley Ro	ad			2070	6			U.S.A		
11. Meritel Stetus		edent Ever in U	,s. 13.	Was Decedent o		igin? (Spec	cify Yes or No		ice - America ack, White, e	
1 Never Married 2 Merr		2 1 No		1 ☐ Yes 2 ☑ N			moun, ord.,	Speci		
3₺ Widowed 4 Divorced	Year or Do	ates:		100 2,010				Speci		White
15. Decedent (Specify only highes	t's Education st grade completed)		16a. Dece	dent's Usuat Occ kind of work dor DO NOT use reti	cupation ne during mos	st of workin	ig .	16b. Kind of I	Business/Ind	lustry
Elementary/Secondary (0-12)	Cottege (1	I-4or 5+)								
8 17. Father's Name (First, Middle,	last)		Inte	rior De			(First Middle	Self-	Emplo	yed
						1000110022			uno)	
Walter Albert P		-	10h 14e in	na Addenaa /Cass			ell Ga		n State 7:-	Code
19a. Informant's Name/Relations		0		ng Address (Stre				1	II, SIBIR, ZID	C000)
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1 Burial 2X Cremetion		State	cemetery, cres	matory or other p	place)					
4 Donation 5 Other (S)		Met	-	tan Cre		-	28/00	Alexand	lria,	VA
21. Signature of Funeral Service	Licensee	1		2. Name and Add			, P.A.			
Henry	. Stark								a MD	2070
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State Registrar

**Funeral** Director

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

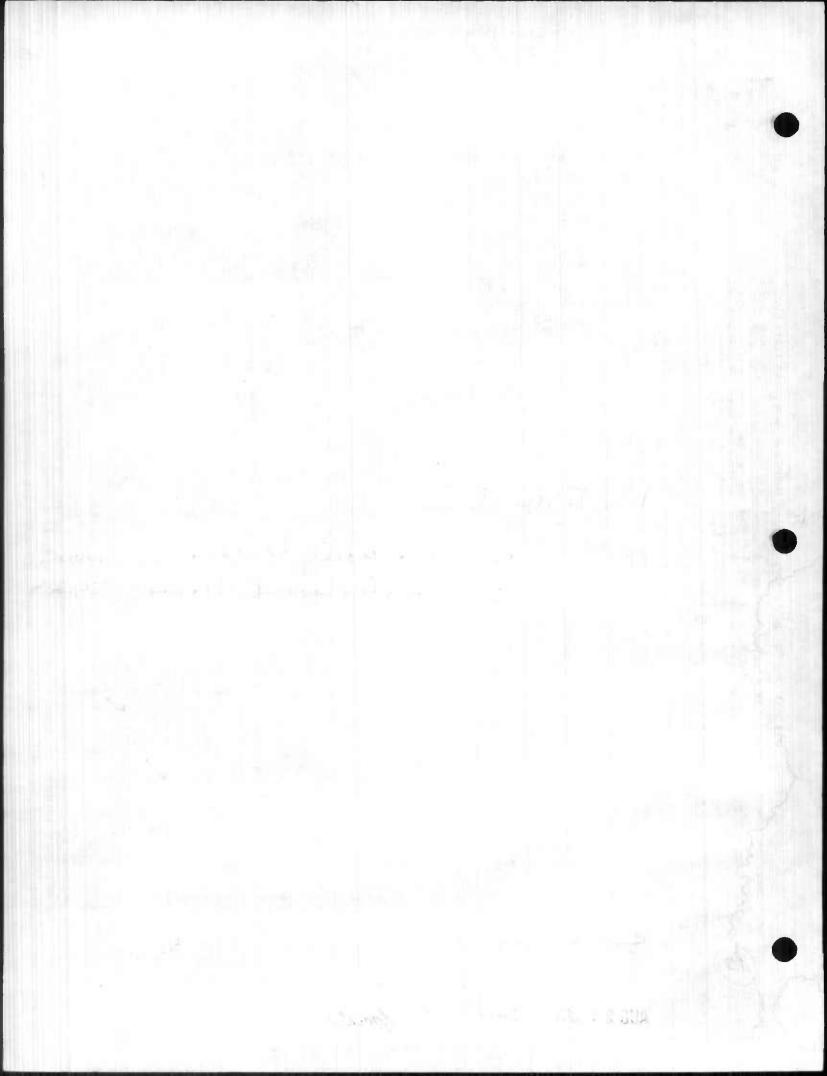
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 24 2000 10:00AM August ROBERT POWELL /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 7202 Martins Court Lanham Prince George's If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Country)
Ohio **Funeral** 1₩ 2□ F Days Months 25, 579-38-0428 68 Director Aug. Usuet Residence of Decedent the Maryland 10h Count 10c. City, Town or Location 10a State 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 7202 Martins Court 20706 Norms 23a United States Funeral 12. Was Decedent Ever in U,S. Amed Forces? 1 △ Yes 2 □ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Bleck, White, etc. African 72 hours efter 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 natural, or 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced American Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry a filed within 7 al Hygiene. Elementery/Secondary (0-12) 12th College (1-4or 5+) Heating/Air Conditioning Self-Employed 18. Mother's Neme (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: if frem 27 is marked other eny injury or other traumatic event, obdes. 17. Father's Neme (First, Middle, Last) Unknown Evelyn Powell 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Shirley E. Powell - Spouse 7202 Martins Court, Lanham, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stete 8/29/2000 Crownsville, MD Maryland Veterans Cem. 4 Donetion 5 Other (Specify) 22. Name end Address of Facility 21. Signature of Funeral Service Licensel Stewart Funeral Home ensay 4001 Benning Rd., N.E. Wash., 20019 ns that caused the death. Do not enter the mode of dying, auch es cerdiac or respiretory arrest, use on each line. Approximata Intervet Between Onset and Deeth **Physician** /Medical Immediate Cause (Finet disease or condition resulting in deeth) Examiner Examiner that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or trijury that initiated events physician and the burial-trans Due to (or as a consequence of) Box 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of). 88 Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. been signed by the should be detached 3 Probably 4 Unknown 1 ☐ Yas 2 ☐ No Division of Vital Records. Completed by 24a. Wes an eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 : 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica director, 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Certification: To 1FTYes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Metural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of trijury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide filled in To the Hospital of within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

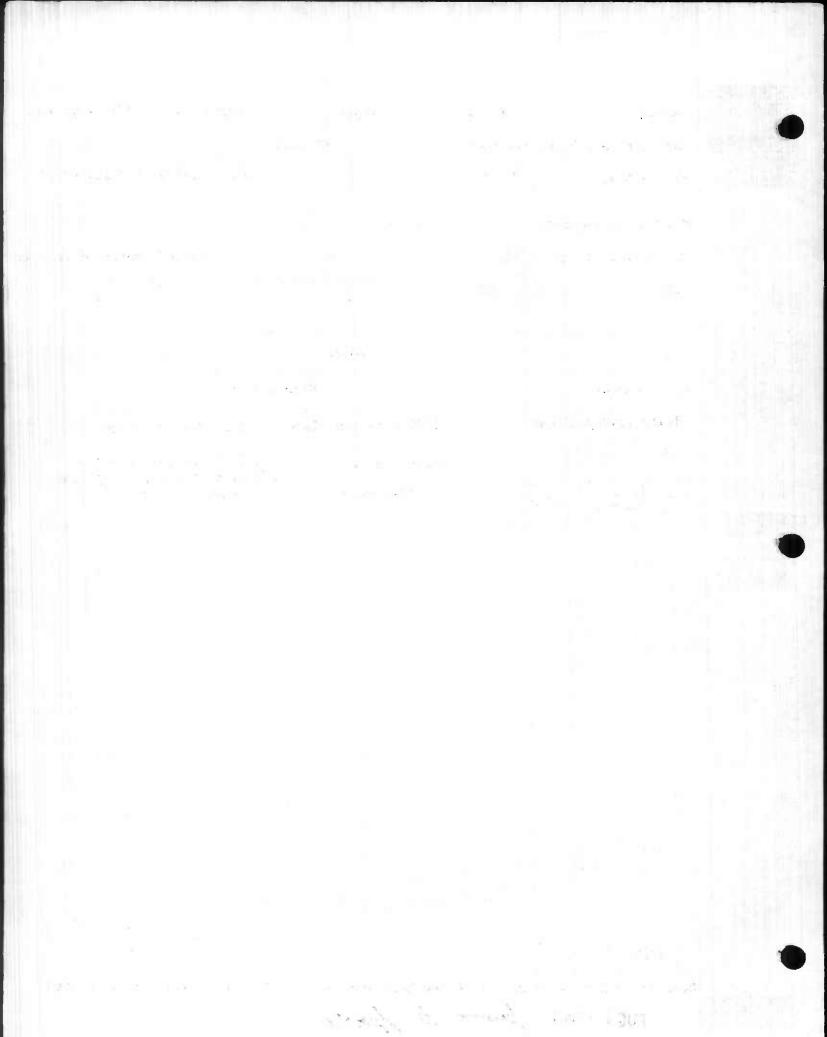
The dical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted. Medical 29e. Certifier 29b. Signature and title of certifie 29c. License number 29d. Det signed (Month, Dey, Year) 8 SS 00 D16410 15 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) Gabrielle Jaffe - 7500 Hanover Parkway, Suite 105, Greenbelt, MD 20770 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State AUG 2 9 2000 Registrar



State of Maryland / Department of Health and Mental Hygiene

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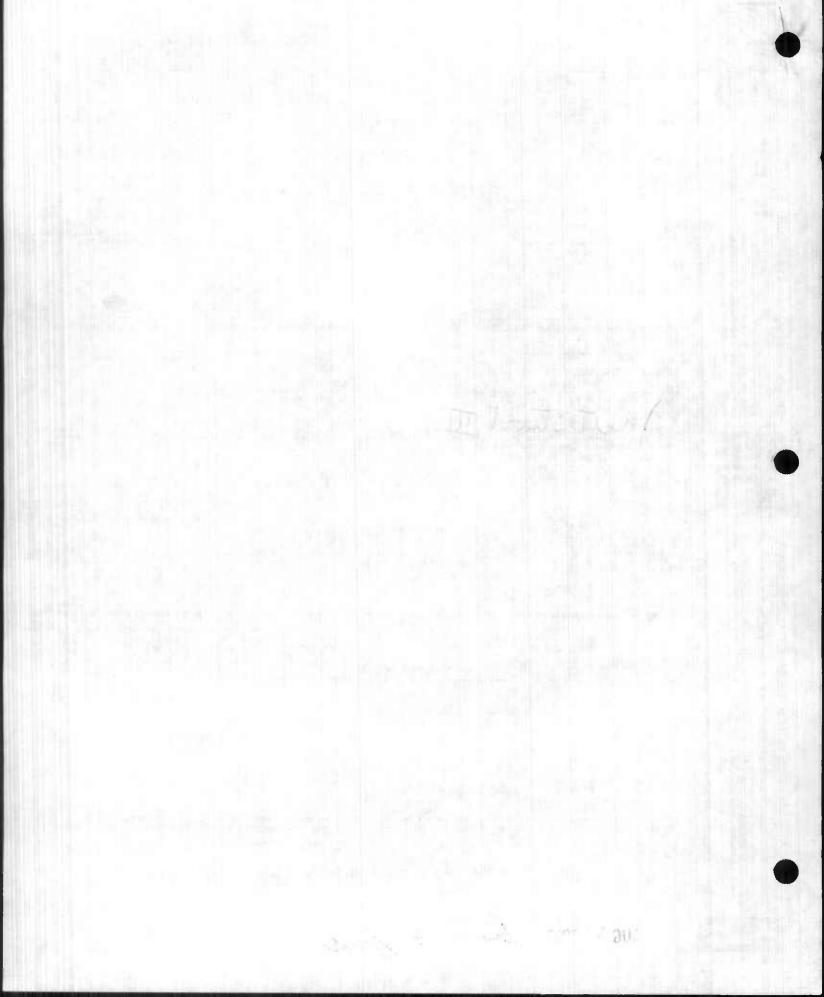
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xaminer		la. Facility Name (If not institution	n, <i>give street</i> end	number)				4	b. City, To	wn, or Lo	cation of Dea	ath 4	c. County	y of Death	
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ToBeC	il.	William Payne									R. Bel				
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State of Maryland / Department of Health and Mental Hygiene

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			Ce	rtificate of	Death	R	leg. No.	U	63106
10 1000	1, Decedent's Name (First, Middle, La	st)		130.		2. Date of Dea Month	th Day	Year	3. Tima of Death
Physician /Medical	Charles Alfred	Proctor				August	28 2	000	7:50AM
Examiner	4a Facility Name (If not institution, gh	re street and number)			4b. City, Town, or I	Location of Death	4c. County	of Death	
	Fox Chase Nurs	ing Home			Silver	Spring	Mo	ntgo	mery
Funeral Director	579-42-3253	7. Age (In )	yrs. last birthday) 5 Yrs.	Months Day		8. Date of Birth (Month, Dey Sept. 4	, Year)		elace (Stete or Foreign etry) ryland
2 .	Usual Residence of Decedent  10e, State 10b, County	100	. City, Town or Lo	ocation				1	Od. Inside City Limits
or 28a-t sho be notified at Director	District of Col				ington				1 Yes 2□ No
	10e. Sfreef and Number 2520 - 12th	St., N.W.		10f. Zip Code	20009	1	log. Citizen of W Unit		<sub>lty?</sub> tates
_ 1 = 1 2	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 Yes 2 No lif Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☐ N	Hispanic Origin? (Saban, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race Blac Specify	k, White,	en Indian, etc. ack
i 21215-0 sd within 72 ho rejere. we then 'nature, it, the Medical.	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occ kind of work don DO NOT use reti	e during most of wor	rking	16b. Kind of Bu	sinass/Ind	Justry
21 21 an	8th		L	aundry V	Vorker		Priv	ate	
Maryland 21215-0020 d 2 should be filled within 72 hours at th and Merital Hygiene. The meritad other than "natural", or traumetic event, the Medical Exam To Be Completed by I	17. Father's Name (First, Middle, Last Melvin Proctor				- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	ne (First, Middle, lary Swai		e)	
Mary nd 2 shot off and N 27 is mary c tysums	19a. Informant's Name/Relationship ( Charles K. Proc	** **		-	St., Mt.			=	Code)
altimore, mil. Pages 1 a portant: If then y injury or othe	20a. Method of Disposition  1 🖾 Burlal 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Speci	Removal from State		osition (Neme of metory or other p		Date 9/6/2000	20c. Location		
Balti pemit. 3 Departm Importar any inju	21. Signature of Foneral Service Lice			2. Name and Add	ress of Facility	Stewart	Funeral	Hom	e
	23a Part1 Paler the disease, or com	plications that caused the cone cause on each line.	Jeath. Do not en		enning Rd. ying, such as cardia				Approximate Interval Between Onset and Death
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Chycnic Due t	06 SW	quence of):	fiel mon	ary di	sean took.	1 1 8 9	
Box 68760, seth certificate be executed attending physician and for use as the burial-transit clary-Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due t	o (or as a consec	quence of):					
	Part It. Other significant conditions of	contributing to death but not	resulting in the u	inderlying cause	given in Part I.	23b. Did to	obacco use cor	tribute to	o the cause of death?
by the tached				, noon, mg accor			/as 2□ No	3 ☐ Pro	
0 8 58 9						24a. Was a			ere autopsy findings allable prior to
The same							med?	of	mpletion of cause death?
= = = 0	og Warner der den med en de la					1 U Y		11	Yes 20 No
Of Vital Physician: The sentificate ral director, pa	25. Was case referred to medical examiner?	Hospital:		-5	Whor:	ath (Check only or			
Phy Phy	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatie 28b. Time of Injury	of 28c. tn	jury at ork?	tome 5 ☐ Resid 28d. Describe h	ow injury occurr		γ)
Division of the or Attending P is a ther death.  at Director: After the in by the funers Certification:	3 Suicide 6 Could not be determined		At home, farm, sf	reet, factory, offic	е	28f. Location (5 City or Tow		er or Auri	al Route Number,
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune Medical Certification		ysician: To the best of my niner: On the basis of exan and manner stated.							
Nethin Fo the comp	29b. Signature and title of pegallier	0.0		29c. Lice	nse number	1	29d. Date signed	d (Month,	Day, Year)
	1//	YSICIAN	Mary 02/1		054566		8/29/00		
	30. Name and address of person who S. BHOCA ULL	2 8609 2va	d AUG,		4043	SILUER	25 prin	۵,۲	10 20910
State Registrar	31. Date filed (Month, Day, Year) AUG 3 1 200	32. Registrar's S	B.	Long					



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Dec No							

Physician				Certifica	te of Death		Reg. No.			
Uhucician	1. Decedent'a Name (First, Midd					2. Date o	Death	Year 3. Time of Death		
Physician /Medical	Marie	Poindex	ter			Augu	st 25, 200	00 12:50pm		
Examiner	4a Facility Name (# not institution		or)		4b. City, T	own, or Location of D	eath 4c. County	of Death		
	Foxchase Nurs			W.11.	Silv	er Spring	Montgo			
uneral	5. Social Security Number 578-09-4567	6. Sex 7. /	Age (In yrs. las 98	Month:	er 1 Year If Unde s Days Hours	Min. 8. Date of (Month	Day, Year)	9. Birthplace (State or Fore Country)		
irector	Usual Residence of Decedent		90			May 2	8, 1902	Washington, D.		
B 14	10a. State 10b. Count	у	10c. City, 7	Town or Location				10d. tnside City Lim		
thed the	D.C.		Wash	ington				1½ Yes 2□		
or 28a-fa be notified Directo	10e. Street and Number				ip Code		10g. Citizen of V	What Country?		
	461 H. Street	N.W. #223			20001		United States			
st, or items 21st Examiner must by Funeral	11. Marital Status  1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	If Yes Give	s? I No		edent of Hispanic Coecify Cuban, Mexico	rigin? (Specify Yes o an, Puerto Rican, etc. y:	Blac	ca - American Indian, ck, White, etc. y: Black		
tr. the Medical E		nt's Education est grade completed)		16a. Decedent's Us (Give kind of v life. DO NOT	vork done during mo	ost of working	16b. Kind of Bu	usiness/Industry		
Con Con	8			Printing	Press Ope		Priva			
B sed	17. Father's Name (First, Middle	(Last)				her's Name (First, Mic		ne)		
To To	Unknown					ty Timber				
The state of	19a. tnformant's Name/Relation Dorothy Woodl:					ber or Aural Route No N.E. Wash				
2 2	20a. Method of Disposition	4 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	20b. Plac	ce of Disposition (N		Date		- City or Town, State		
= 10	N Burial 2 ☐ Cremation		te cem	netery, crematory or	other place)	9/5/00		1000		
E C	4 Donation 5 Other (3		FL.	Lincoln	and Address of Eac	ilibu		ood, Md.		
Man and and and and and and and and and a	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Alexander S. Pope Funeral Homes									
	23a. Parl1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate the triangle of the death									
ģ.	shock, or heart failure. Lis	t only one cause on each	line.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			tnterval Between Onset and Death		
ysician ledical	Immediate Cause (Final			1 /	ه ر د		. 0 ./			
aminer	disease or condition resulting in death)	a. Re	Spire	atory to	allun c	vita Bila	He Kal PICC	200		
ē 1		0	Due to (or a	is a consequence o	1):	1	Atus	(COG)		
bunal-transit		b. Coru	Due to for a	ascelar						
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.2 3	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			s a consequence o	1):	lent				
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his cartificate has been signed by the attending phys It director, page 2 should be detached for usa as the To Be Completed by Physician/Medic	Part It. Other eignificant conditions are sulting in death) Last  Part It. Other eignificant conditions are successful and suc	d	Due to (or as but not resulting the property of the property of the property of the property of examination of	s a consequence of s a consequen	26. Pla  26. Pla  26. Pla  26. Pla  27. Pla  28. Injury at Work?  1 Yes 2 [  28. ory, office  29. License numbe	ce of Death (Check of Nursing Home 5 1 28d. Description 28d. Description 28d. Location City of and place, and due to be ath occurred at the terms.	Did tobacco use co    Yes 2   No    Nas an autopsy performed?    Yes 2   No   No nily one)   Residence 6   Other ibe how injury occur   On (Street and Numbrown, State)    the cause(s) end meme, date and placa,   29d. Date signed	antributs to the cause of des 3 Probably 4 Onkn  24b. Were autopsy finding available prior to completion of cause of death?  1 Yes 2 No  ther (Specify)  med  ber or Rural Route Number,  enner as stated, and due to the cause(s)  ed (Month, Day, Year)		
fler this certificate has been signed by the attending physineral director, page 2 should be detached for usa as the on: To Be Completed by Physician/Medic	Part It. Other eignificant conditions are sulting in death) Last  Part It. Other eignificant conditions are successful as a serie of the summer?  25. Was case referred to medical examiner?  1	d	Due to (or as but not resulting the polynomial of the polynomial of the polynomial of examination stated.	s a consequence of s a consequen	26. Pla  26. Pla  26. Pla  DOA Other: 4  28c. Injury at Work?  1 Yes 2 [  ory, office  ad at the time, date a con, in my opinion, do  29c. License numbe	ce of Death (Check of Oursing Home 5   28d. Desc   No 28f. Location City of Ci	Did tobacco use con 1 Yes 2 No  Nas an autopsy seriormed?  I Yes 2 No  nly one)  Residence 6 Other or one (Street and Number Town, State)  the cause(s) and meme, date and placa,  29d. Date signe	antributs to the cause of dea  3 Probably 4 Onkn  24b. Were autopsy tinding available prior to completion of cause of death?  1 Yes 2 No  ther (Specify)  med  ber or Rural Route Number,  enner as stated, and due to the cause(s)  and (Month, Day, Year)		
fler this certificate has been signed by the attending physineral director, page 2 should be detached for usa as the on: To Be Completed by Physician/Medic	Part It. Other eignificant conditions are sulting in death) Last  Part It. Other eignificant conditions are successful and suc	at Hospitat: 1 Inpering to death VC feld at Hospitat: 1 Inpering tigation and provided the texaminer: On the basis and manner or the texaminer: On the basis and manner or the texaminer: On the texaminer: On the basis and manner or the texaminer: On the basis and texaminer: On the b	Due to (or as but not resulting the polynomial of the polynomial of the polynomial of examination stated.	s a consequence of s a consequen	26. Pla  26. Pla  26. Pla  DOA Other: 4  28c. Injury at Work?  1 Yes 2 [  ory, office  ad at the time, date a con, in my opinion, do  29c. License numbe	ce of Death (Check of Oursing Home 5   28d. Desc   No 28f. Location City of Ci	Did tobacco use con 1 Yes 2 No  Nas an autopsy seriormed?  I Yes 2 No  nly one)  Residence 6 Other or one (Street and Number Town, State)  the cause(s) and meme, date and placa,  29d. Date signe	antributs to the cause of des 3 Probably 4 Onkn  24b. Were autopsy finding available prior to completion of cause of death?  1 Yes 2 No  ther (Specify)  med  ber or Rural Route Number,  enner as stated, and due to the cause(s)  ed (Month, Day, Year)		

State of Maryland / Department of Health and Mental Hygiene

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00	2	9	1	5	-

DC	NALD R	AY
	Physic /Med Exami	ical ner
ı	Funeral Director	0
Baitimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Introcramt: if Item 27 is marked other than "natural", or ferms 23s or 28s-f show any injury or other traumatic event, the Medical Estatrician must be notified at Obca.	To Be Completed by Funeral Director

PERKINS	Certificate of Death
1. Decedent's Nama (First, Middle, Last)  DONALD RAY	Perkins
4a Facility Neme (If not institution, giva street end num	

HOSPITAL

2. Data of Death AUGUST 24

3. Time of Death 2000 0500

4b. City, Town, or Location of Death CAMBRIDGE

4c. County of Death DORCHESTER

10g. Citizan of What Country?

Specify:

577-13-1045 Usual Residence of Deceden 10h County

5. Social Security Number

DORCHESTER

1 M 2 F 10c. City, Town or Location

If Under 1 Yaar | If Under 24 Hrs. 7. Aga (In yrs. last birthday) Months Days

10f. Zip Code

Yrs.

8. Date of Birth (Month, Day, Year) Min. Hours 07-16

18. Mothar's Nama (First, Middla, Maidan Sumama)

Birthplace (Stata or Foraign Country)

10d. Inside City Limits

1 2 Yes 2 No

10a State 10e. Street and Number 2835 11. Marital Status

PER 1. Dec

> Washing Nisville ST. S.E 12. Was Decedant Evar in U,S. Armed Forcas?

100ZO Was Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxicen, Puarto Rican, atc.)

S.F 14 Race - Amarican Indian Biack, Whita, atc.

Black

1 Nevar Married 2 Married 3 Widowed 4 Divorced 15. Decedant's Education (Specify only highast grada completed)

Elementary/Secondary (0-12)

1 Yas 2 H If Yes, Give Yaar or Datas:

Collega (1-4or 5+)

llema

2 12 No

16a. Decedant's Usuai Occupation
(Giva kind of work dona during most of working
lifa. DO NOT usa ratired) 2Choo

1 Yas 2 No Specify:

16b. Kind of Business/Industry

17. Fathar's Nama (First, Middla, Last)

21. Signature of Funaral Sarvice Licensaa

ames &

NATHONO

GENERAL

hRYSTA. 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code)

19a. Informant's Name/Relationship (Type, Print) erkinis heliA

20b. Place of Disposition (Nama of cematary, crametory or other place)

WAShinston D.CZ00ZO Data 20c. Location - City or Town, Stata

20a. Method of Disposition

1 Dauriai 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify)

-, 1202

09-02-00 brone. Mary knd ationa

22. Nama and Addrass of Facility illorent 5732 Georgia N-W. WASh, O.CZOOII tre

**Physician** /Medical Examiner

physician and as the bunal-trans

60 attending a

signed by the a

page 2

director,

this

after death.

Director: After the in by the funeral

Immediata Causa (Final disaasa or condition rasulting in daath)

Head injunies

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Diseasa or Injury that initiated events rasulting in death) Last

Dua to (or as a consequance of)

Dua to (or as a consequence of)

Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I

23b. Did tobacco uss contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy

24b. Wara autopsy findings svailable prior completion of causa of death?

1 Yas 2 No

1 Nas 2 No

Approximata Interval Between Onset and Death

25. Was casa rafarred to medicel examinar?

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28b. Tima of

28c. Injury at Work? 1 Yas 2 No

Other: 4 Nursing Homa 5 Rasidance 8 Other (Spacity) 28d. Dascribe how injury occurred Collision motor vehicle

26. Place of Death (Check only ona)

281. Location (Street and Number or Rural Route Number City or Town, State) R+, 50 | Res lyn Ave

29a. Cartiliar (Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated.

O.C.M.E

29d. Data signad (Month, Day, Year)

30. Nama and address of person who complated ceusa of daath (ften 23a) (Typa, Print)

Stephen S.
31. Data filed (Month, Day, Year) Radentz

32. Registrar'a Signatura

DHMH 16 Bev 6/95

**ORIGINAL** 

The law requires that the death certificate be assecuted P.O. Division of Vital Records. or Attending Physician: To the Hospital or within 24 hours after To the Funeral Discompletely filled in

Box 68760,

Physician/Medical þ Completed Be

Examiner

10

Certification:

edicai

State Registrar

1 Yas 2 No 27. Mannar of Death 1 Natural

4 Homicide

5 Pending 2 Accident 3 Suicida

invastigation 6 Could not be datarmined

8-24-2000 28e. Plece of Injury - At home, farm, streat, factory, office building, atc. (Specify)

234

111 Penn Street, Baltimore, Maryland 21201

Street

Denchester County, Maryland

Certifying Physician: To the best of my knowledge, deeth occurred et the time, data end piece, and due to tha ceusa(s) and manner as stated.

29c. Licansa number

AUGUST 25,2000

NUS 3 & 20M

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year August 22, 2000 Ellis 10:15 AM Houston 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Harford Churchville 11 Rockdale Ave. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 9, 1905 Birthplece (State or Foreign Country) Alabama 5. Sociei Security Number 7. Age (In yrs. last birthday) Days Hours 110 M 2□ F Yes 95 217-12-3194 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Maryland Harford Churchville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 21028 11 Rockdale Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, Bleck, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Detes: 1 Never Married 20 Merried 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) U.S. Government Operating Engineer 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Carry (nmn) Bradshaw Carey Mack Price 19e. Informent's Neme/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stela, Zip Code) 11 Rockdale Ave., Churchville, Maryland 21028 Ruth H. Price / Wife 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 8-25-00 1 █ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Darlington, Maryland Deer Creek Harmony Pres. Cem. 22. Name and Address of Facility McComas Funeral Home, P.A. 21 Signature of Funeral Service Licensee 23a. Part I. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or haen feilure. List only ona cause on each line. Much 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximete Interval Between Onset end Deeth Immediata Cause (Finel disease or condition resulting in deeth) Acute Cerebrovascular Accedent Due to (or as a consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): Due to (or es a consequence of): 23b. Did tobacco use contributs to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown

**Physician** /Medical Examiner

Department of Health and Mental Hygens Important! If Health and Mental Hygens Important! If them 27 is mental other than "nu any injury or other traumatic event, the same 2009.

**Physician** 

/Medical

Directo

Funeral

Completed

Be

Examiner

**Funeral** 

Director

ö 238

21215-0020

Maryland

Saltimore,

The lew requires that the death certificate be exacuted P.O. Box 68760 94 signed by Records, certificate of Vital Physician: this

Physician/Medical Examiner þ Be Completed Certification: To

To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

Division

104

Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Drabetes Mellitus Type II Cerebrovascular Accident SIP 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Recurrent Univery injections 2 3 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Skin Cancer 25. Wes casa rafarred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 25 No 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 TYes 2 □ No investigation 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29c. License number

29b. Signeture end title of certifier MIR2A A-BAIC MD

29d. Date signed (Month, Dey, Year)

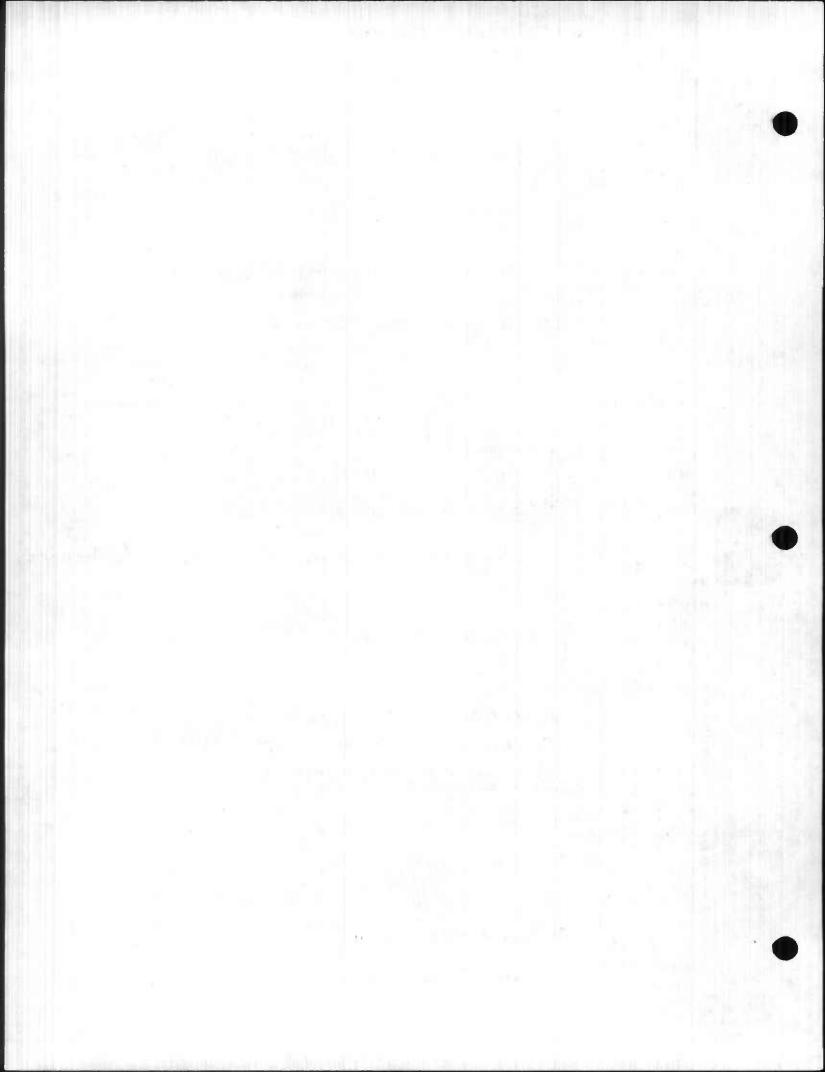
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - Union

Havre De Grace, MD 21078

State Registrar

Medical

31. Deta filed (Month, Day, Year) AUG 2 4 2000 32. Aegistrar's Signature



1	-	STATE REGISTR	AF
L	D	ECEDENT'S	N/

### STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAN		CERT	IFICAL	E UF	DEA	I H		REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)			24		***		2. DATE (	OF DEATH	AY	YEAR	3. TIME OF DEATH 10
	Madelle B		ton					Augu	st 26	, 200	00	ALOO PH
	219–18–0498	5. SEX 6.	AGE (In yrs. lest birthde 76 YRS	MONTHS	DAYS	HOURS	24 HRS.	7. DATE O (Month, June	17, 1	924	Country	PLACE (State or Foreign
	9a. FACILITY NAME (If not institution, give a	treet and number)		9b. CIT	Y, TOWN	OR LOCATI	ON OF DI			-	ITY OF DE	
DR	Union Hospital				Flk	ton					[eci]	
5	RESIDENCE OF DECEDENT					COII					CCII	_
RE	10a. STATE 10b. COUNTY		10c.	CITY, TOWN	OR LOCA	TION						10d. INSIDE CITY LIMITS?
۵	Maryland H	arford		Aberd	een							1 YES 2X NO
AL	10a. STREET AND NUMBER				10	r. ZIP COD	E			10g. CITI	ZEN OF W	HAT COUNTRY?
FUNERAL DIRECTOR	306 Irish Lane					210	01				U.S.	Α.
5	11. MARITAL STATUS	12. WAS DECEDENT E		13.	WAS DEC	ENDENT (	F NISPA	NIC ORIGIN?	(Specify Yes	or No-	14. RACE	- American Indian,
B⊀	1 Never Married 2 Mairied 3 Wildowed 4 Divorced	IF YES, GIVE WAR			1 YES	ecity Cube	m, Mexica Specif	an, Puerto Ri fy:	can, etc.)			White
回	15. DECEDENT'S EDUI (Specify only highest grade	CATION completed)	16a. DECEDEN' (Give kind	of work done	durina mo	ON ost of worldi	20	16b.	KIND OF BUS	SINESS/IND	USTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)		omema.					Ten la se			
MC	17. FATHER'S NAME (First, Middle, Last)		п	unena	ver	1	UEDIO NA	AME (First, Mi	In ho			
	Carl Brown							elle K				
BE	19a. INFORMANT'S NAME (Type/Print)		195 MAN	NG ADDRES	S (Street )			Route Numbe			0-4-1	
2	Mrs. Donna L. C	asev (Daug						erdee				1001
	20a. METHOD OF DISPOSITION		20b. PLACE AND DA				, 20	DATE		CATION — (		
	1 Buriel 2 Cremation 3 Rem-	oval from State	spesutia	cemet	ery			8/3				aryland
	21. SIGNATURE OF FUNERAL SERVICE LIC	EMSEE / / /		22.	NAME A	O ADDRE	SS OF FA	CILITY				
	> +	1 600	7. 11		Tarr	1ng-(	arg	o Fun	eral	Home,	P.A	١.
	23. PART I. Enter the diseases, or o	complications that co	nused the death D	o not enter	Aber	deen	Ma	rylan	a 210	001-3	399	Approximate
NO	ahock, or heart failure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions,	Resp	Meratony Man A COMSEQUENCE		lve	C						interval Between Onset and Death
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OF	AS A CONSEQUENCE  AS A CONSEQUENCE  ALO PULM	Obx 1	opai	thy 17	me.	st				6 days
- 11	PART II. Other eignificant condition	e contributing to de	eth but not resultin	g in the di	nderlyin	ceuse (	lven in	Part I.	24e. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
MEDICAL								_	PERFOR	. /		AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTI	RIBUTE TO CAUS	SE OF DEATH	YES 🗆	NO [	UNC	ERTAIL	N				
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF D	OTHE	-							
Z	1 - YES 2 NO	1   Inpetient 2   El	VOutpatient 3 - DOA			e 5 🗆 Re	sidence	8 - Other	(Specify)			
E	27. MANNER OF DEATH  1 Natural 5 Pending	28a. DATE OF INJ (Month, Day,		IME OF	28c. INJ WO	URY AT		26d. DE\$C	RIBE HOW II	NJURY OCC	VRED	
B	1 Natural 5 Pending 2 Accident Investigation			M.		rES 2	NO					
ETED	3 Suicide 8 Could not be determined	28s. PLACE OF IN building, etc.	IJURY — At home, farm (Specify)	n, street, fac	tory, offic			28f. LOCAT	ION (Street a Town, State)	nd Number	or Rural Ac	oute Number,
Ш	29a. CERTIFIER			7								
COMPL	(Check only one)  1 CERTIFYING PHYSIC ONE)	R: On the basis of exam										
ဗ	296. SIGNATURE AND TUTLE OF CERTIFIER		1 22 1		.,,,,,,				nu piece, eix		-	
띪	JULIE OF CENTRER	11/1/10	1/2/11/11			29c. LICE	NSE NUN	MBER	71	29d. DATE	SIGNED	(Month/ Day, Year)
2	30. NAME AND ADDRESS OF PERSON WIN	COMPLETED CALLED	DE DEATH (ITEM 37 (	me Ori-11		1/	UU	405	//		0/6	1100
	101 Color	nal We	11.	pe, Print)	SUL	,10	10	219	911	CAM	Mony	Wolk, Jr. MD
	31. DATE FILED (Month, Dey, Year)	32. REGISTRAR'S	SIGNATURE A	10	20 11	1						

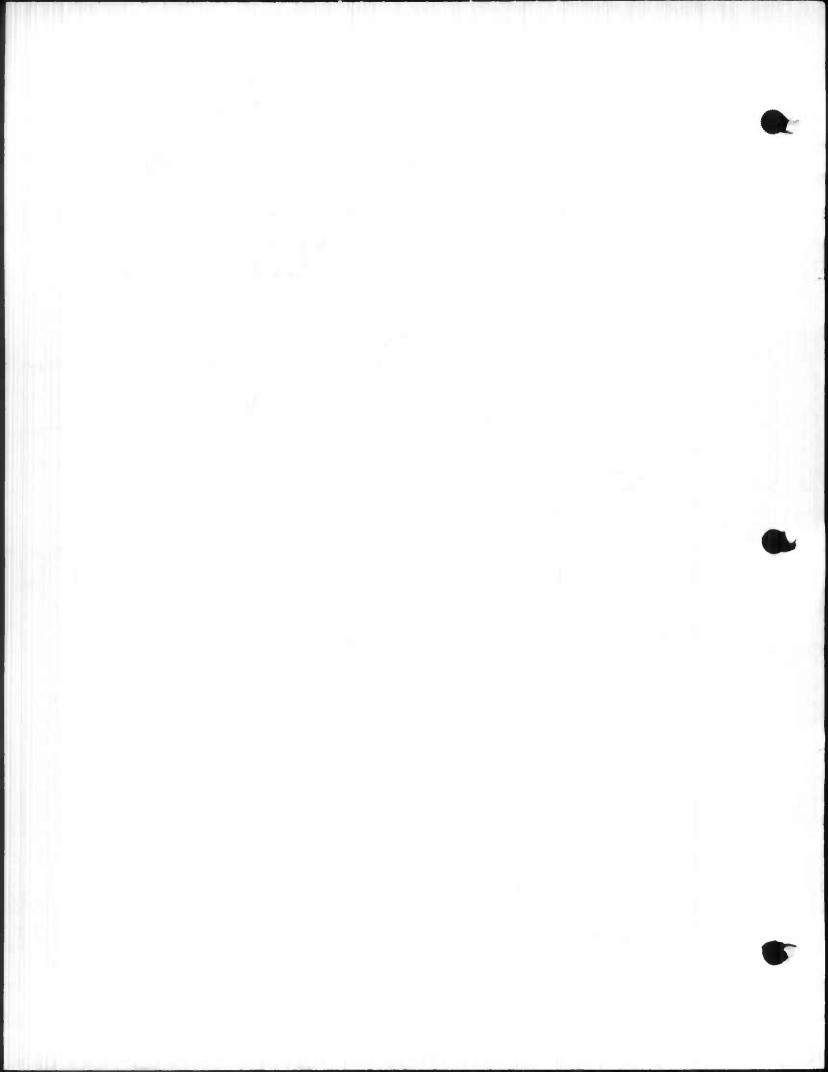
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

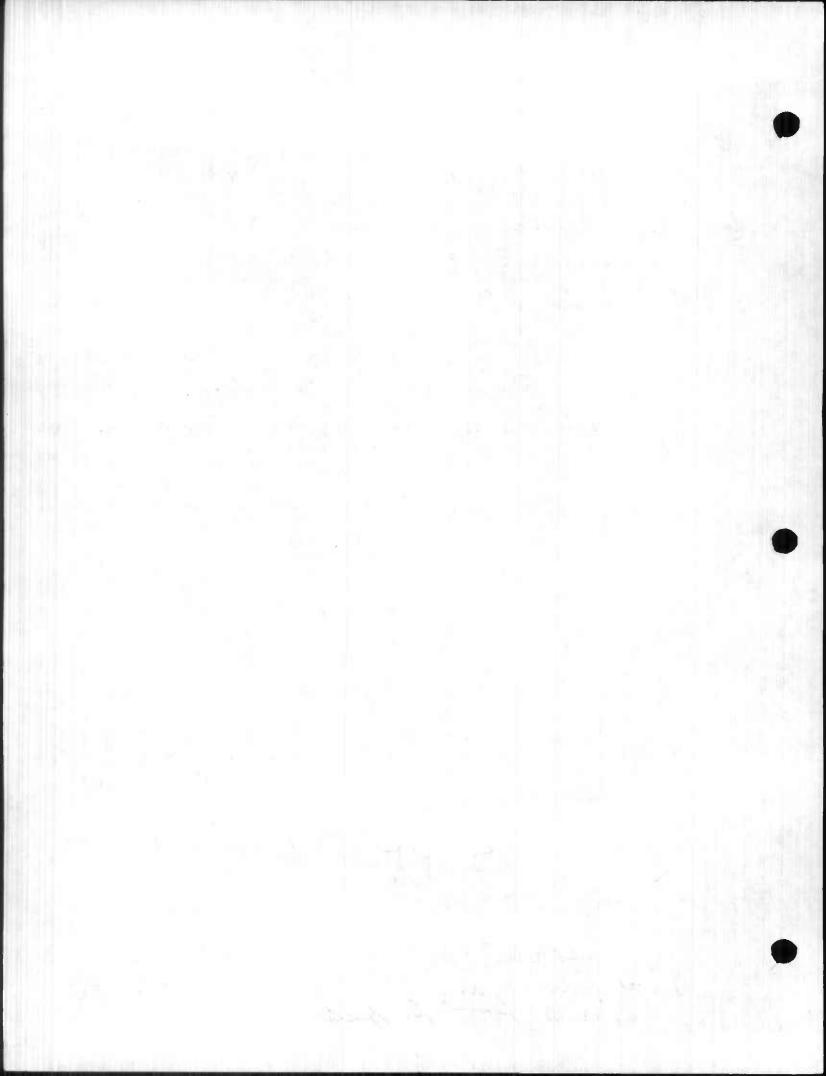
IMPORTANT: If them 28 is marked, or liem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

10



			Certificate of	f Death	Reg	. No.	
	1. Decedent's Name (First, Middle, Las	0			2. Date of Death Month	Dey Year	3. Time of Deeth
Physician /Modical	CHERYL	LUNN PE	STERS		August	27. 2000	12:00 Noo
/Medical Examiner	4a Fecility Neme (If not institution, give			4b. City, Town, or L		4c. County of Deat	
	109 E. Williams S	treet		Salisbur	v	Wicomic	0
Funeral	Social Security Number     6. Security Number		est birthday) If Under 1 Ye Months Day	ar If Under 24 Hrs.	8. Dete of Birth (Month, Day, Y		hplace (State or Foreign
Director	214-70-5023 1 Usual Residence of Decedent	□M 2 <b>X</b> F	Yrs. Working Da	ys Hours Nat.	4-6-	59	Mp.
# H	10a. Stele 10b. County	10c. City,	, Town or Location				10d. Inside City Limits
to the	MD Wico	MICO	SALISBUR	U			1 XYes 2 No
be notified Director	10e. Street and Number		10f. Zip Cod		10g	. Citizen of What Co	untry?
	1012 Queent	MIN STAFFT	- 2	2/801			USA
instructions 234 instructions Funeral	11. Marital Status	12. Was Decedent Ever in U,S	5. 13. Was Decedent of	of Hispanic Origin? (S) uban, Mexicen, Puerto	pecify Yes or No-	14. Race - Ame	
新 五	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No			o Rican, etc.)	Black, White	
by by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 Yes 2 X	lo Specify:		Specify:	BLACK
ted bet	15. Decedent's Ed	ucation	16a. Decedent's Usual Oc	cupation	16	b. Kind of Business/	Industry
of the Medical Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use rel	ne during most of work ired)			
A E	CTED	College (1-401 3+)	CASH	IER	E	AGLE CLA	ORESS STORE
event, Be C	17. Father's Neme (First, Middle, Last)				ne (First, Middle, Ma		
To B	SAMUEL	PETERS		SARAH	GREEN	JONE	5
1	19a. tnformant's Name/Reletionship (7		19b. Meiling Address (Stre				
tran tran	JERYL YOUN	G - SISTER	1212 POCOH	DATTAS AL	IE SAI	ISBUDIL A	10 21841
ed)	20e. Method of Disposition	20b. Pla	ace of Disposition (Name of		Date 20	c. Location - City or	Town, State
= 8	1 Burial 2 Cremation 3	Removal from State	metery, crematory or other	Diaca)	olala.	1	
min.	4 Donetion 5 Other (Specify 21. Signature of Fune al Service Licen		PRINGHILL CE	METARY	7/5/2000	HEBRON,	4.4
Pin (	21. Signature of Funeral Service Licen	721	22. Name and Ad	dress of Facility	BENNIE	SMITH	FIH
	Just y	54		SABELLA S			1D. 21801
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death. one cause on each line.	. Do not enter the mode of	dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between
sician		C	(	1 -		17.12.1	Onset and Death
edical	Immediate Cause (Final disease or condition	74	rangula	Ton			
miner	resulting in death)	Due to (or	es a consequence ot):				
e e						8	
burial-transit	Sequentially list conditions.	b. Due to (or	es e consequence of):				
	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury						
physician s the buria edical E	trial initiated events	C. Due to (or	es e consequence of):				
2 4	resulting In death) Last						
I for use a		d					
d fo	Pert ff. Other eignificant conditions of	entributing to death but not resul	Iting in the underlying cause	given in Pert I.	23b. Dfd tob	acco use contribute	to the cause of death
detached detached					1 🗆 Yes	1.1	robably 4 Unknow
be det						1	
					24a. Was an		Were autopsy tindings available prior to
s been s should					реполи		completion of cause of death?
page 2					.Ac		
C. pa	05 Mt				Yes		10 res 2 No
is certificate has b director, page 2 s To Be Compli	25. Was case referred to medical examiner?	Hospital:		Other:	ath (Check only one)		
0 0	1 No 27. Menner of Death	1 Unpatient 2 UE	ENOutpatient 3LI DOA	4 U Nursing n	lome 5 Residen 28d. Describe how	ca 8 Other (Spe	at scene
To the Funeral Director: After this completely filled in by the funeral Medical Certification: 7	1 Natural 5 Pending	(Month, Day Year)		njury at Work?	C. Lescribe now	Thomas decurred	-led
the Cat	2 Accident investigation 3 Suicide 6 Could not be	UM	UVF	Yes 2 No	sonea	31700	2000
at Director: After t led in by the funeral Certification:	Homicide determined	28e. Placa of Injury - At hor building, etc. (Specify,	me, ferm, street, factory, offi	ce	281. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
P O			UNK			UNK	
Ne Funer pletely fill edical		sician: To the best of my know iner: On the basis of examinati					
Ped pe	one)	and manner stated.		, opinion, doon ood			
To T	29b. Signature and title of certifier	1	29c. Lic	onse number O.C.M.E.	290	d. Date signed (Moni	th, Day, Year)
	P/ Lack	te MIN		O.C.M.E.	Z	August 28,	2000
	30. Name and address of person who d	completed cause of deeth (Item	23a) (Type, Print)				4.7
	J. LARON In	CKP III		Street, Ba	altimore,	Maryland	21201
Ŝtate	31. Date tiled (Month, Day, Year)	32. Aegistrar's Signet	ure /				
2012112	AUG 3 1 200	7 Recent	D. Sport	-1			



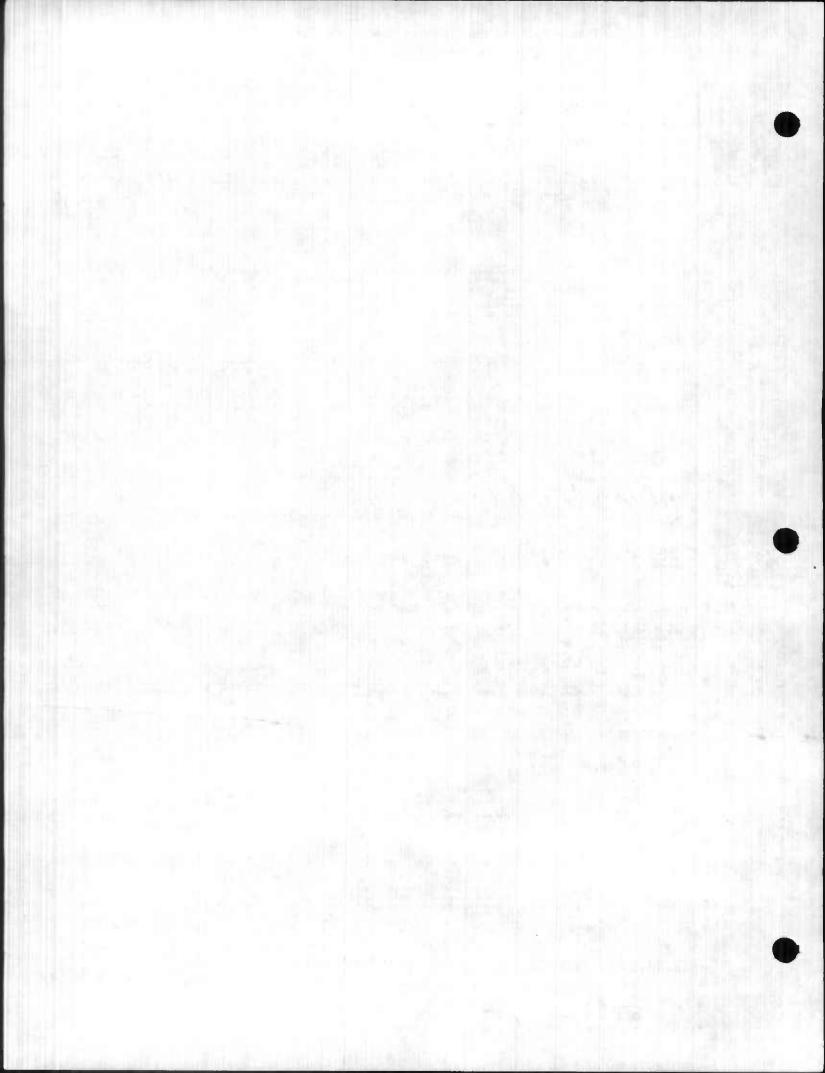
## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death		Reg. No.	0 29158
	Physician	1. Decedent's Neme (First, Middle, Last)	2. Dete of De		3. Time of Death
	/Medical	VIRGINIA B. ROSS	Morg.	30 2000	12:35 p.m
-/	Examiner		or Location of Deet		COMERY
-	Francis	SHADY GROVE ADVENTIST HOSPITAL ROCKV  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) H Under 1 Year H Under 24			
L	Funeral Director	173-12-9727  Usual Residence of Decedent	Ain. Sept.	y, Year) 20 1917	P. Birthplace (State or Foreign Country)
	yland Mow	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	th with the Maryla 23e or 28e-f sho unt be notified at ral Director	Maryland Montgomery Rockville			Yes 2□No
	or 21s-f s be notified Director	10e. Streef and Number 10f. Zip Code		10g. Citizen of Wh	at Country?
	ath v	9701 Veirs Dr. 20850		USA	A
21215-0020	nal, or thems. Examiner m.	11. Manital Stetus  1 Never Merried 2 Merried  3 Nightidowed 4 Divorced  12. Wes Decedent Ever in U,S. Armed Forces?  1 Yes, 2 Nightidowed 1 Divorced  13. Was Decedent of Hispanic Origin, If Yes, specify Cuban, Mexican, Polity Pes, Give Year or Detes:	r (Speciny Yes of No uerto Rican, etc.)	Bleck,	American Indian, White, etc. White
5	ed within 72 ho ygiene. er then 'natura. It the Medical.	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of	working	16b. Kind of Busi	ness/Industry
121	Mithin Man	Elementary/Secondary (0-12) College (1-4or 5+)			
d 2		12 0 Homemaker 17. Father's Neme (First, Middle, Last) 18. Mother's	Neme (First, Middle	Own Hom	e
lan	Mental Parkad off wheat off white ever affic ever To Be	11: 11: D1 :	ha Soles		
Maryland	M pun	19a. Informent's Neme/Reletionship (Type, Print)  19b. Mailing Address (Street and Number of	r Rural Route Numb	er, City or Town, St	ate, Zip Code)
	atth a	Edward Ross (Son) 1203 Forest Lake Dr	. Great F	alls, VA	22066
altimore	of He	20e. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Dete	20c. Location - C	ty or Town, Stete
Ě	Page ment: If any or	Our Lady Queen Of Peace	9/2/00	House Spr	ings, MO.
Balt	Depart Depart Import any in	22. Name end Address of Fecility Hysong Co. 6510 16th. St.	NW Washi	naton D	C 20012
1		23a. Pert1. Enter the disease, outcome catche that caused the deeth. Do not enter the mode of dying, such as car shock, or heert tellure. List cryy one date is on each line.	diec or respiretory e	rrest,	Approximate Interval Between
	Physician	V			Onset and Deeth
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)			days
	ē	Due to (or as a consequence of):			
	ntificate be executed on physician and set the burial-transit	Sequentially list conditions.  Due to (or es e consequence ot):			
60,	be ex clan clan burial	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or es e consequence of):			
68760,	ifficete be ng physicie es the bu	that initiated events resulting in death) Last  Due to (or es e consequence of):			
Box	nding use s	d			1
	death cer e attendir ed for use	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Dld	tobacco use contr	ibute to the cause of death?
P.0	the state of				□ Probably 4 □ Unknown
	by be	Liver cancer, hypertension			
ord	The law requires at a has been significate has been significated by Completed by		24a. Wes	en eutopsy ormed?	24b. Were autopsy findings available prior to completion of cause
Sec	The law stands beage 2 stands				of deeth?
a F	cata he		10	Yes 2 No	1 □ Yes 2 No
of Vital Records,	Physician: The rai director, page To Be Co	exeminer? Hospitel: C	Deeth (Check only		
	Physic arthis c aral dire	27. Menner of Death 28a. Dete of Injury 28b. Time of 28c. Injury et	ng Home 5 ☐ Resi	how injury occurred	
lo	Attending P or death. ector: After by the funer iffication:	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No			
Division	or Attendiate death. Director: A in by the fi	3 ☐ Suicide 4 ☐ Homicide  See Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location ( City or To		or Rural Route Number,
ō	late or Attending P rs after death. el Director: After t led in by the funer: Certification:	building, atc. (Specify)	Ony or ro	Wit, Olato)	
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in Medical Cert	29e. Certifier (Check only one)  1X Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end placed in the control of the best of my knowledge, deeth occurred et the time, date end placed in the control of the best of my knowledge, deeth occurred et the time, date end placed in the control of the best of my knowledge, deeth occurred et the time, date end placed in the control of the best of my knowledge, deeth occurred et the time, date end placed in the control of the best of my knowledge, deeth occurred et the time, date end placed in the control of the best of my knowledge, deeth occurred et the time, date end placed in the control of the best of my knowledge, deeth occurred et the time, date end placed in the control of the best of my knowledge, deeth occurred et the time, date end placed in the best of my knowledge, deeth occurred et the time, date end placed in the best of my knowledge, deeth occurred et the time, date end placed in the best of my knowledge, deeth occurred et the time, date end placed in the best of my knowledge, deeth occurred et the time, date end placed in the best of my knowledge, deeth occurred et the time, date end placed in the best of my knowledge, deeth occurred et the time, date end placed in the best of my knowledge, deeth occurred et the time, date end placed in the best of my knowledge, deeth occurred et the time, date end placed in the best of my knowledge, deeth occurred et the time, date end placed in the best of my knowledge, deeth occurred et the time, date end placed in the best of my knowledge, deeth occurred et the time, date end placed in the best of my knowledge, deeth occurred et the time, date et al. The best of my knowledge, deeth occurred et the time, date et al. The best of my knowledge, deeth occurred et al. The best of my knowledge, deeth occurred et al. The best of my knowledge, deeth occurred et al. The best of my knowledge, deeth occurred et al. The best of my knowledge, deeth occurred et al. The best of my knowledge, deeth o	lece, and due to the occurred at the time,	cause(s) and menr dete and place, an	ner as stated. d due to the cause(s)
	Withir Comp	29b. Signeture end fittle of certifier 29c. License number	10	29d Dete signed	
	0	Patricia & Tomsko ms D5191	6'	Hugus	7 30,2000
	(1)			n	H 30,2000
		Patricia L. Iomsko, MI, 11140 Kockville Pike, F	MB 348	Kocky	1/e, INV 20852
	State Registrar	SEP 0 1 2000 32. Registrer's Signature			

State of Maryland / Department of Health and Mental Hygiene

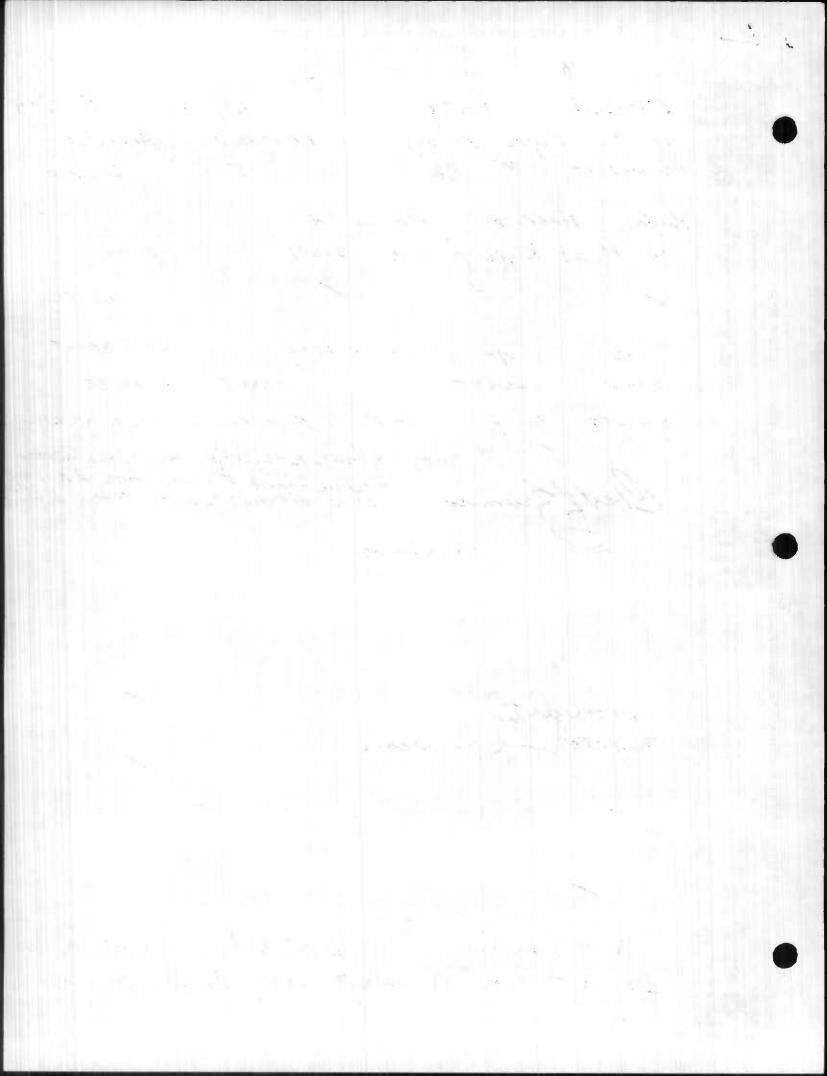
			State of Mary		tificate o			Reg. No.	0 6	.510.3
	Physician	1. Decedent's Name (First, Middle, La					2. Dete of De Month	Day	Year	3. Time of Death
100	/Medical	Charles his	7 -				08		000	12:54 am
	Examiner	4a Facility Name (If not institution, giv University of Mary		Center		4b. City, Town, or Baltimo		Baltir		City
1	Funeral	5. Social Security Number 6. S	ex 7. Age (In	yrs. last birthday)	If Under 1 Yes			th Yearl	9. Birthpl	ace (State or Foreign
н	Director	222-22-0370	M 2□ F	63 Yrs.	MOMIS Day	S MOUIS WIII.	01-08	1937		mington, Dl
	how how	Usual Residence of Decedent 10a, Stata 10b, County	100	c. City, Town or Lo	cation				10	Od. Inside City Limits
3	is death with the Marya items 23e or 25e-f short feer must be notified at furneral Director	Delaware Suss	ex	Lewes						1 Yas 2 No
	or 28s-fu be notifie Directo	10e. Street and Number			10f. Zip Code		75	10g. Citizen of W	hat Count	ry?
- 3	E 128	RD 2 Box 145B				958		USA		
	r hems 23 iner must Funeral	11. Mantal Status	12. Was Decedent Ever Armed Forces?	in U,S. 13. \	Was Decedent of I Yes, specify Cu	Hispanic Origin? (S ben, Mexican, Puer	to Rican, etc.)	Bieck	- America	
020	uraf, or	1 ☐ Never Married 2 ☑ Merried 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1□ Yes 2☐N	Specify:		Specify:	wh	nite
0-0	natura fical E	15. Decedent's Ed		16a. Deced	dent's Usuai Occ	upation	anti-	16b. Kind of Bu	siness/Ind	ustry
218	ed within 72 ho yglene. wer than "natur f., the Medical.	(Specify only highest gra	College (1-4or 5+)	life. I	DO NOT use reti	e during most of wo red)	rking			
2	The The		5+	CI	A Offic	cer		U.S.	Gove	ernment
Pu .	B source	17. Father's Name (First, Middle, Last)				18. Mother's Ne	me (First, Middle	, Maiden Sumame	9)	
Maryland 21215-0020	To Ment						A. Al			
Ма	T the man	19a. Informant's Name/Ralationship ( Noi Riggin (wi	,, ,		2 Box	et and Number or R	u <i>ral Route N</i> umb iewes ,			Code)
100000	Healt Ser Z	20a, Method of Disposition		Ob. Place of Dispo	sition (Name of	1	Dale Dale	20c. Location - 0		wn. State
altimore,	rages national ray or o	1 □ Bunal 2 □ Cremation 3 □	Removal from Steta	cemetery, crer	natory or other p					
# ;	referred and and and and and and and and and an	4 ☐ Donation 5 ☐ Other (Specify		Gracelar 3717 22	Wn Mem		09/06/			Castle, Di
Ba	de de la companya de	Nichola DI	Reollell							omes, Inc DE 19803
		23a. Part1. Enter the disease, or com abock, or heart fallure. List only	plications that caused the	death. Do not ent	er the mode of d	ying, such as cardia	c or raspiratory	errest,		Approximate interval Batween
	hysician									Onset and Deeth
	/Medical Examiner	Immediate Cause (Final disease or condition	. Metast	atic C	ancer					
)	APPLICATION .	resulting in death)	Due	to (or as a consec	quence of):			17-14-1		
	i ii		b. Melanc	ma					i	
	n and iai-transit	Sequentially list conditions, if any, leading to immediate	Due	to (or as a conseq	juance of):					
99	physician and the burial-transit sub-burial-transit sellcal Examin	Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury	C	te Car					-	
68760,	off s	that initiated events resulting in death) Last		to (or as a conseq						
	attending for use a		d. Renal	Cell C	arcino	ma				
Вох	y the attending sched for use a hysician/M	Part II. Other significant conditions of	patributing to death but no	t requiting in the u	ndarhina anusa i	thian in Part I	23h Did	tohacco use con	tribute to	the cause of death?
P.0	ad by the attending detached for use a	Part II. Other significant conditions of	orithoding to death but no	t teaching in the o	noonying cause (	givent in rest i.				bably 4 Unknown
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ğ								an eutopsy omed?	24b. We	ere autopsy findings
of Vital Record	ate has been s page 2 ahould Completed						pon	oour	COL	mpletion of cause death?
E 3	Page Dage						10	Yes 2 No	1	Yas 2□ No
		25. Was casa raferred to medicai				26. Place of De	ath (Check only	one)		
> 3	this ceral direction.	axaminer? 1 ☐ Yes 2⊠ No	Hospital:	2 ER/Outpatien	nt 3 DOA	Other: 4 Nursing I	Home 5 Res	idance 6 Othe	ır (Specify	,
0 5	ter th neral	27. Manner of Death 1.⊠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Tima of	28c. In	ury at ork?	28d. Dascribe	how injury occurr	ed	
io i	he fu	2 ☐ Accident investigation	1		M 1	☐ Yes 2☐ No				
Division	or Attendang raystoners as after death.  In Director: After this certifice led in by the funeral director, Certification: To Be (	3 Suicide 6 Could not be datermined	28e. Place of Injury - building, etc. (S)		eet, factory, offic	0	28f. Location City or To	Street and Numbe wn, State)	er or Rura	Route Number,
	C T T T T T T T T T T T T T T T T T T T									
	within 24 hours after to the Funeral Director pletely filled in Director Medical Certi		ysician: To the best of my niner: On the basis of axa and manner stated.							
1	Me thin	29b. Signeture and title of certifier	and manner stated.		29c. Lice	nse number		29d. Date signed	(Month, I	Day, Year)
D '	8 = 8	1 1	Franco	MA		12399		8-3		
	16	30. Name and address of person who	/			1211		0 )		
	10	DANIEL .	T. FRANGO	MD, UMM	S MEDIC	INE 20.	S. GKEEN	EST BAL	T. 41	> 21201
	State Registrar	31. Date flied (Month, Day, Year) SEP 0 1 2001	32 Registrar's S	Signeture 9.	Spark	2				

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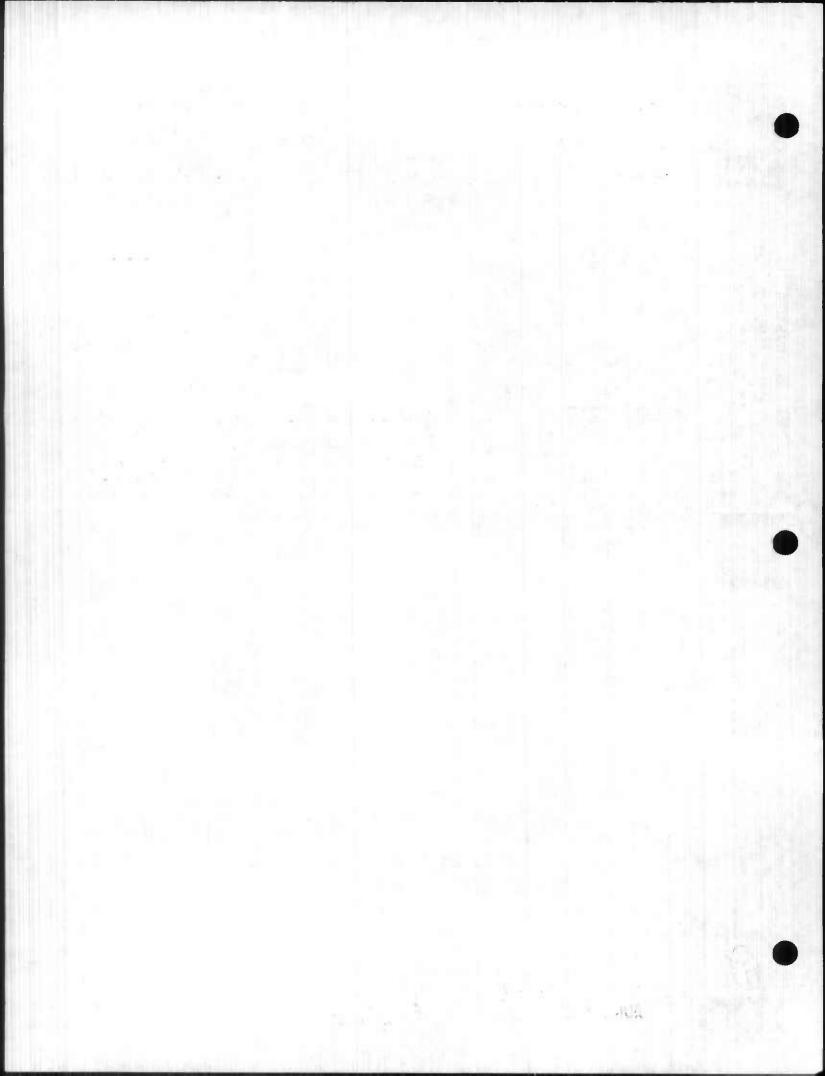
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend item# 0 9/7/00 HCHD BH Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Death Month Year **Physician** 21 Elizabeth 2000 ug /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Aberdeen ROYAL Mount HARFORD RUCNUC If Under 24 Hrs. Hours Min. 5. Social Security Number 6 Set 7. Age (In yrs. lest birthday) If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F 82 Months Days 316-18-2945 Yrs. LNDIANA Director **=**01/30/1918 Usual Residence of Decedent the Manyland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 22 No Therdeen MARYIAND HARFORD Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or itsms 23a or treumstic event, the Medical Exampler must be a W.S.A. 21001 KOYAL lount Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Whit Specify: p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pagas 1 and 2 should be filed within tent of Health and Mental Hygiena. nt: If item 27 is merked other than " Elementery/Secondary (0-12) College (#-4or 5+) GOVERNMENT SECRETARY 12 1/19 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be BesSIF TESSE ELLIOTT PERSLEE 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ROYAL AUC ELLIOTT 24 Mount ABERDEEN, MD. 21001 20b. Place of Disposition (Name of cametery, cremetory or either place)
RISING SUN New Cemetery 8 20e. Method of Disposition 20c. Location - City or Town, State permit. Pagas Department of Important: If It eny injury or o 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State ISING SUN INDIANA 4 Donetion 5 Other (Specify) 21. Signature of meral Service Licansee 22. Name and Address of Fecility Mitchell -WASHINGTON STREET HAVRE de GRA 5. 123 23a. Part1. Enter the disease, of compicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final osis disease or condition resulting in death) Examiner Examine physician and the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es a consequenca of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequenca of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? nal syndrome 24a. Was an autopsy Completed page 2 1 ☐ Yes 2 ☐ No 1 □ Yes 2PINO or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28c. Injury et Work? 27. Manner of Deeth 28e. Date of Injury (Month, Dev Year) 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes investigetion 2 Accident after deat Director: 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 24 hours after Funeral Directors pletaly filled in b 4 Homicide 29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai To the Hosp within 24 ho To the Fune completely fi 2 ■ Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cartifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abendeen D. WAINUT 31. Date filed (Month, Dey, Yeer) 32 Registrer's Signeture State AUG 2 2 2000 Registrar



State of Maryland / Department of Health and Mental Hygiene 0 9 16 1

			Cer	tificate of	Death		Reg. No.	0	3101
	1. Decedent's Name (First, Middle, Last)	LUS 11/100	The second	41.		2. Date Mont	of Death	Year	3. Time of Death
Physician /Medical	Lavinia F. Sawye	er				Augu	st 27,200	00	7:56AM
Examiner	4a Facility Name (If not institution, give street	t and number)			4b. City, Tow	n, or Location of	Death 4c. Count	y of Death	
	Charles County Nursi	ng & Rehab	center		LaPlat	a	Ch	narles	
Funeral Director	5. Social Security Number 6. Sex 1 M	7. Age (In yrs. la 20 F 92	ast birthday) Yrs.	If Under 1 Year Months Deys		Min. 8. Dete	of Birth th. Day, Year) 25,1907	Count	th Carolir
anyland show ed.at	Usual Residence of Decedenf  10a. State 10b. County		, Town or Loc	cation				10	Od. fnside City Limits
or 28a-fa be notified	Maryland Charles  10e. Street and Number	La	Plata	10f. Zip Code			10g. Citizen of	What Count	10.2
	11.2 1			20646			U.	S.A.	
ours after death ours after death of the Examiner mant	XXWidowed 4 □ Divorced	Vas Decedent Ever in U,5 umed Forces? □ Yes 2 (XNo Yes, Give 'ear or Dates:		Vas Decedent of Yes, specify Cut		n? (Specify Yes Puerlo Rican, ef	or No- c.) 14. Ha Bla Specia	ce - America ick, White, e fy:	
72 hours natural, dical Exu	15. Decedent's Educatio (Specify only highest grade con	n noleted)	16a. Deced	ent's Usual Occu	pation during most of	of working	16b, Kind of B	lusiness/Ind	Lothrop
led within 72 ho ygians. we than "naturit, the Medical.	Elementary/Secondary (0-12)	college (1-4or 5+) N/A		kind of work done 00 NOT use retire alesperse			Depart		
d other Hy	17. Father's Name (First, Middle, Last)						liddle, Maiden Sumai	me)	
Ments b Ments b mile e	Lawrence	Fox			I	avinia	Bush		
of 2 should be filed within 72 hours at the and Mental Hygiens.  27 is marked other than "natural", or a traumetic event, the Medical Exam.  To Ba Completed by 8	19a. Informant's Name/Relationship (Type, F Martha Talbert (Da		19b. Mailin 1305	g Address (Stree Greengat	t and Number te Ct.	or Rural Route N Waldorf	Number, City or Town , Maryland	State, Zip 1 2060	Code)
emit. Pages 1 a bepartment of Hea mportant: If them, my injury or othe MSS.	20a. Method of Disposition  1 ☑ Burial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)			sition (Name of natory or other pla con Natio			000 20c. Location Suitla		wn, Stata Maryland
Departm Departm Importar eny injur	21. Signatury of Funeral Service (Censes		22	. Name and Addr	ess of Facility	Lee Fu	neral Home	e, Inc.	_
Physician	23a. Parf1. Enter the disease, or complication shock, or heart failure. List only one call	ns that coused the death use on each line.	. Do not ente	er the mode of dy	ing, such as c	erdiac or respirat	tory arrest,		Approximate Intervel Between Onset end Death
/ /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	Congest	- P	Heard	Fa, le	ert	776.4	1	
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executed in and hal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		as a conseq						
ath certificate be executed attending physician and for use as the burlal-transit clary.	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a consequ	uenca of):				1	
death ce attendi ed for use								-	
d by the setached		ling to death but not resu	ilting in the ur	nderlying cause g	iven in Part I.	23b	1 Yee 2 No		the cause of death? bably 4 Unknow
aw requires is been sign 2 should be						249.	Was an autopsy performed?	ave cor	ere autopsy findings alleble prior to mpletion of cause death?
The lav							1□ Yes 2 No	10	Yes 2 No
detan: The certificata rector, pag	25. Was case referred to medical examiner?				26. Place	of Death (Check	only one)		
g Physician: er this certific neral director,	1 ☐ Yes 2 No Hospi 27. Manner of Death 20	tal: 1   Inpatient 2   E	ER/Outpetien 28b. Time of Injury	t 3 DOA O			Residence 6 Ot		0
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	Be. Placa of Injury - At ho building, etc. (Specify	me, farm, str	M 10	Yes 2 N	28f. Loca	tion (Street and Num or Town, State)	ber or Rura	l Route Number,
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4)	30. Name and address of person who complete Larry Jenkins, M.I	V ·			ata, Mo	i.			
State Registrar	31. Date filed (Mogth Day, Year) AUG 2 8 2009	32 Registrer's Signet	ture	Lond	,				



State of Maryland / Department of Health and Mental Hygiene 00 29162

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month Yaa **Physician** Robert E. Smith August 26 2000 9:40 P.M. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Hospital Center Cheverly Prince Georges If Under 24 Hrs. 5. Sociel Security Number If Under 1 Year 6 Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** Months Days 10 M 20 F Hours 004 18 6014 83 Director Jan. 4, 1917 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. Stete 10d. Inside City Limits 1 Yes 2 No Directo 288-4 Maryland Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 12302 Starlight Lane 20715 United States therms 23s Funeral 14. Rece - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 No Yes 2 □ No If Yes, Give Year or Detes: WWI. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merifel Status 72 hours after 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 "natural", or Specify: White 1 ☐ Yes 2 ₹ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WWII Completed 18e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Thysiene. Elementery/Secondary (0-12) College (1-4or 5+) pormit. Pages 1 and 2 should be liked in Department of Health and Mental Hygien Important if Item 27 is marked other the any injury or other traumatic Salesman Paint Industry 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fathar's Neme (First, Middle, Last) Be Robert K. Smith Melvina Horan 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 12302 Starlight Lane Bowie Maryland 20715 Jessie V. Smith Wife 20b. Place of Disposition (Name of cametery, crametery, crametery, crametery, crametery) or other place) August 29, 2000 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory Alexandria Virginia 21. Signeture of Funeral Service License 22. Name end Address of Fecility Robert E. Evans Funeral Home 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest,

Approximately a such as cardiac or respiretory errest, Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disaase or condition resulting in death) Examine Examiner attending physician and for use as the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es a consequence of): 68760 the death certificate be Physician/Medical thet initiated events resulting in death) Last Due to (or es a consequence of): Box P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 3 Probably 4 Unknown 1 Yes 2 No Records, à 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Wes an eutopsy performed? Completed page 2 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Wes case referred to medicel examiner? Be 26. Place of Death (Check only one) 1 Yas 2 No Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After or Attending 1 ENeturel 5 Pending investigation death. 1 ☐ Yas 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 4 ☐ Homicide after To the Mospital o within 24 hours at To the Funeral DI completely filled in 1K Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edicai 29a. Certifier (Check only one) 29b. Signeyure and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number 5000 and cause of deeth (Item 23a) (Type, Print) many land 0 31. Dete tiled (Month, Dey, Year) 32 Registrer's Signeture State

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State of Maryland / Department of Health and M	Mental Hygiene	0.0	29161
Certificate of Death	Reg. No.		49107
	2. Date of Death		3. Tima of Death

				Certifica	ate of	Death		Reg. No.		29164			
hysician	Decedent's Name (First, Middle	, Last)					2. Date of De Month	ath Dey	Year	3. Time of Death			
/Medical			ITH	11.274			August		2000	1:15 pm			
aminer	4a Facility Name (If not institution					4b. City, Town, or	Location of Deat	4c. County	of Death				
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eral etor	577 20 7555 Usual Residence of Decedent	12M 2□F		Yrs. Month				1921	Virgi	lace (State or Foreign try) nia			
u	10a. State 10b. County		10c. City, Town	or Location					10	0d. Inside City Limits			
a notified	Maryland Prince	George's	Capit	ol Heig	hts					1 Yes 2 No			
al Director	10e. Street and Number 6303 Carrington		200	10f.	2ip Code 20743			10g. Citizen of V USA	What Coun	try?			
Funeral	11. Marital Status	12. Was Deceden Armed Forces		13. Was De	cedent of	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No	14. Rac	e - America				
by	1 Never Married 2 Narr 3 Widowed 4 Divorced		No. 1944-46	1 □ Yes	2/2 No		to mosti, otc.,		Bla				
pete	15. Decedent (Specify only highes		16a.	Decedent's U (Give kind of	work done	duning most of wo	rking	16b. Kind of B	6b. Kind of Business/Industry				
Completed	Elementary/Secondary (0-12)	College (1-4or		life. DO NOT	use retin	ed)	11 273						
	12	anti	P	ostal (	Carri		me /First stiddle			Office			
89	17. Fether's Name (First, Middle,		4-14-11				me (First, Middle		10)				
70	Benjamin Frankl			Mailing Add	ee (Circ		Judkins		State Zin	Code)			
	19a. Informant's Name/Reletionship (Type, Print)  19b. Meiling Address (Street and Number or Rural Route Number, City or Town, St  6303 Carrington Ct. Capitol Heights, N												
0 6 5	Daisy Stith /wife 6303 Carrington Ct. Capitol Heights, MD  20a. Method of Disposition 1 Date 20c. Location - City or 1  20b. Place of Disposition (Name of cemetery, crematory or other piece)  20c. Location - City or 1												
	4 □ Donation 5 □ Other (S)	ecity)	Mary1a			Cemetery	8-31-00	Laurel	, MD				
any	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  MARSHALL'S FUNERAL H  4308 Suitland Road Suitland, MD 207.  23. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one ceuse on each line.												
cian	shock, or heart lailure. List	only one ceuse on each	line.							Onset and Death			
al er	Immediate Cause (Final disease or condition resulting in deeth)	a. <u>E</u> `	Sopha Due to (or as a	geal	of):	Carcin	oma		1	8 months			
Examiner	Sequentially list conditions,	b	Due to (or as a consequence of):										
dical E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	с	f):										
5 G)	resulting in death) Last	d											
Physicia	Part II. Other eignificant condition	ne contributing to death	but not resulting in	the underlyin	g cause g	iven in Part I.	23b. Did	tobacco uae co	ntribute to	the cause of death?			
by Physician/M				Ling.			1 🗆	Yes 2 No	3 Prot	bably 4 🗆 Unknown			
leted	7				V	24a. Was	an autopsy ormed?	ave	ere eutopsy findings ailable prior to mpietion of cause death?				
Comp							10	Yes 2 No	10	Yes 2000			
Be	25. Wes case referred to medical					26. Place of De	ath (Check only	one)					
0	axaminer? 1 Yes 2 90	Hospital: 1 Inpat	tient 2 ER/Ou	tpatient 3	DOA O	ther: 4 Sursing t	Home 5 ☐ Res	idence 6 🗆 Ott	ner (Specif	y)			
	27. Manner of Death  1 7 Netural 5 Pendin 2 Accident investig	etion	jury ay Year) 28b. 1	Time of njury M	28c. Inj W	ury et ork?  Yes 2 No	28d. Describe	how injury occur	rred				
filled in by the funeral Certification:	3 Suicide 6 Could a determined	nad 206. Flaue UI II	njury - At home, fa etc. (Specify)	rm, street, fec	ory, office		28f. Location ( City or To	(Street and Number, Stete)	ber or Rura	il Route Number,			
etely fill dical		Physician: To the best examiner: On the basis and manners	of examination an										
E 3	29h Signature and title of certified				On Lines	nse number		29d. Date signe	d (Month	Oay Year			

29b. Signature and title of certifier

D37934

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) 29d. Date signed (Month, Day, Year)
8/30/00 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Greenway Center Dive \$ 430 Greenhelt 10 20773 7500 Stephanie Trifod
31. Date Med (Month, Day, Year)

State Registrar

**DHMH 16 Rev 6/95** 

AUG 3 1 2000

32. Registrar's Signeture

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

00 29165

	Certificate of Beat	**	Heg. No.	
Physiciar /Medica	Martin Craid Simpking	2. Date of De Month AUGUST	Day Yes	3. Time of Death 000 14:58 PM
Examine	do Facilità biama de nationale de national de constant de combant	Town, or Location of Deat		
		PITOL HEIGHTS		E GEORGE'S
Funeral Director	578-90-5008 12 M 2 F 40 Yrs. Months Days Hours	ler 24 Hrs. 8. Date of Bir Min. (Month, De Aug. 9	9. E 1960 Wa	Sirthplace (State or Foreign Country) Sh., D.C.
S	Usual Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits
Mary 4 she	Maryland Prince George District Heights			1 XYes 2 □ No
with the Ma a or 28e-f s Lbs notified	10e. Street and Number 1550 Addison Road South 20747		10g. Citizen of What USA	Country?
UZU um sher death ar, or leans 22 Examiner mus	11. Merital Status  1 Never Married  1 Never Married  3 Widowed 4 Divorced  12. Was Decedent Evar In U.S. Armed Forces?  1 Yes, Specify Cuban, Mexic  1 Yes, Give Year or Dates:		14. Raca - Al Black, W Specify:	merican Indian, hite, etc. Black
O-O	15. Decedent's Education (Specify only highast grada completed)  [Give kind of work done during multiple. DO NOT use retired)	nost of working	16b. Kind of Busine	ss/Industry
of within 72 ho ygione. we than 'neturn 4, the Medical	Elementery/Secondary (0-12)  12  College (1-4or 5+)  Maintenance	ost of working	Private	9
D STEPS OF	17. Fathar's Name (First, Middle, Last)	ther's Name (First, Middle ESSIE	, Maiden Sumame) Peri	c.A.
md 2 should be s	19a. Informant's Name/Relationship (Type, Print)  Denise Simpkins (Wife)  19b. Mailing Address (Street and Num. 1550 Addison Ro	nber or Rural Route Numb d., South (D	er, City or Town, State istrict I	. Zip Code) 20747 Igts., Md.)
artimore, mit. Pages 1 a partment of Her contant. If Nem r Injury or othe	20a. Method of Disposition  1 XBurlal 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cametery, cremetory or other place)  Harmony Memorial P	Park9/2/00	20c. Location - City Hyattsvi	
Departit Departit Importu	21. Some and Address of Fac Ste 4001 Bennin	ewart Funer	al Home,	Inc. C.20019)
	23a. Part1. Enter the disease, or complete that that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.			Approximete Interval Between
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  a.   Due to (or as a consequence of):			Onset and Death
68760, ficate be assecuted sphysician and is the bunal-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents  b. Due to (or as a consequence of):	4 1 9		
OX 68760,  certificate be an anding physician a use as the bunal and a state of the sta	Cause (Disease or Injury that initiated avents resulting in death) Last  Due to (or as a consequence of):			
U _ U _ N				
d by detay	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pa		X	uts to the causs of death?  Probably 4 Unknow
0 > 0 0 =		24a. Was	s an autopsy ormed?	b. Were autopsy findings available prior to completion of causa of death?
VITAL KEC		1×	Yes 2□No	1 Yas 2□ No
Man Stans	25. Was case referred to medical axaminer?	ace of Death (Check only	one)	
H sign		Nursing Home 5 ☐ Res		pecity) SCENE
nding ath. r: After se fune	27. Manner of Death  1 Neturel 5 Pending investigation 2 Accident	- GIRTE	how injury occurred	en skif
DIVISION C To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	378.Suicide 4 Homicide  Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  AT Home	28f. Location City or To		A OPISON RP
Hospit 4 hour Funeri	29a. Certifier (Check only)  1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date (Check only)  (Check only)  (Check only)  (Check only)	end place, end due to the	ceuse(s) end manne	as stated.
To the I within 2 To the complet	and menner stated.  290. Signature and title of certifier  290. Licansa number	er	29d. Data signed (M	onth, Day, Year)
	O.C.M.	.E.	AUGUST 29	, 2000
0	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ARRY G. RIPPUE, M.D. 111 Penn Street,	, Baltimore,	Maryland	21201
State Registrar	DUIE 3 1 /IHB Phasener			

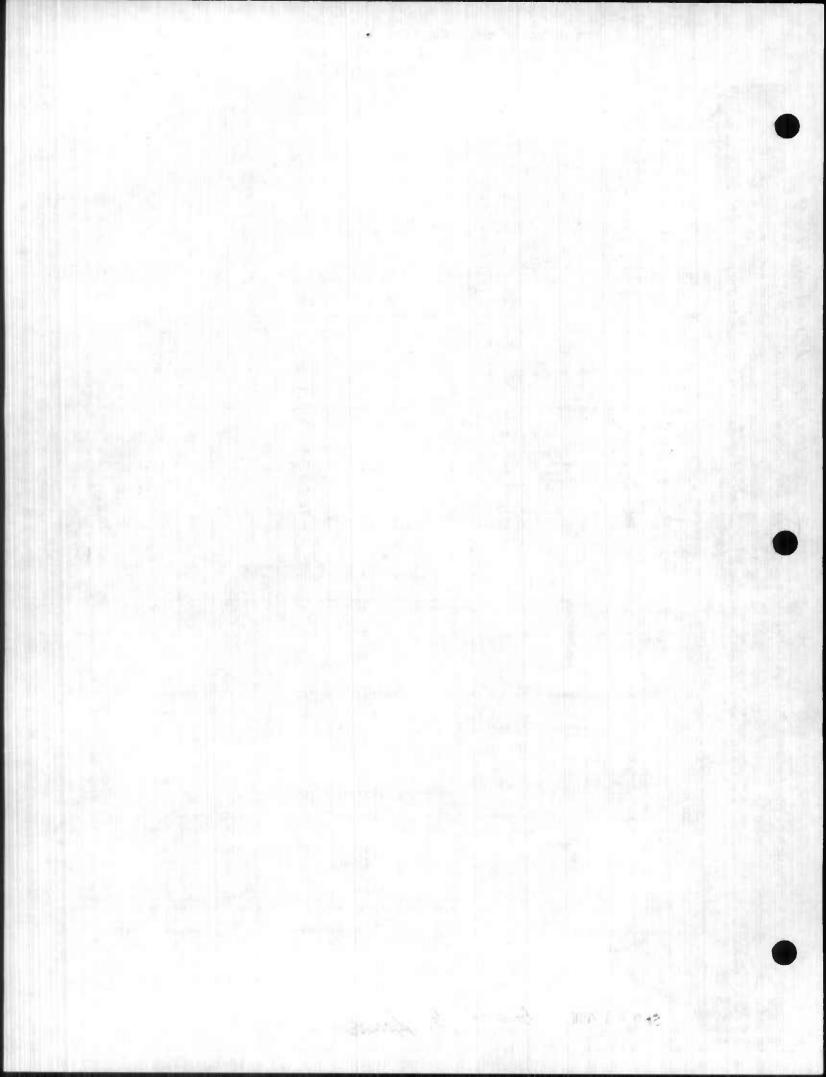
State of Maryland / Department of Health and Mental Hygiene

							Cen	tificate of	Death		Reg. No.	0 6	2100
		_	ecedent's Nam	ne (First, Middle,	Last)		-111			2. Date of De	ath	Vace	3. Time of Death
	Physiciar /Medica		JANET	ANNE	SELLMAN					August	- 26 -	Year 2000	1256 AM
	Examine	4.0	Facility Name (	If not institution,	give street and number	er)			4b. City, Town,	or Location of Deat	dc. County	of Death	
			PriNC	,e 6e	oye's Hos	Dital	Chi	ten	Chev	rely	Prim	ce C	torges
	Funeral	5. S	ocial Security N	Number 6		Age (In yrs. las	st birthday)	If Under 1 Year Months Days		in. 8.Date of Bir	th Voer	9. Birthple	ace (State or Foreign
	Director	2	19-64-4	506	1□ M 2☑ F	45	Yrs.	Months Days	Tiours III	May 24			ngton, D.C.
	D.	-	al Residence o	T		40.00							
	anyla ahove		. State	10b. County		10c. City,	Town or Loc	ation				10	d. fnside City Limits
	N THE	M	aryland	Prince	George's	Non	rth Br	entwood					1⊈ Yes 2□ No
	or 28a-f a	10a	. Street and Nu	mber				10f. Zip Code		E	10g. Citizen of	What Counti	γ?
	after deeth with the Marylan or Nems 23a or 28a-f ahow when must be notified at a function of Engage and Please or Engage at the control of t	3	3912 Wel	bster St	reet			20722			U.S.A		
	r forms 23s	11.	Marital Status		12. Was Deceder Armed Force	nt Ever in U,S.	13. W	as Decedent of I	Hispanic Origin?	(Specify Yes or No erto Rican, etc.)	- 14, Rac	ce - America	
21215-0020	S - 1 2	2	1 ☐ Never Marr 3 ☑ Widowed	ried 2 Married 4 Divorced		Z) No		□ Yes 2⊠ No				Black	
2-0	ed within 72 hours ygiene. or then "neture!", it, tre therical from	3	(Cna	15. Decedent's				ent's Usual Occu		wating	16b. Kind of B	usiness/Indu	stry
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21	filed with Hygiene. ther ther	5	lementery/Second 12t1	h			Schoo	ol Cross	ing Gua	rd	Gover	nment	
pu	EIEE .			(First, Middle, La	ast)				18. Mother's h	Name (First, Middle	Maiden Suman	ne)	
/ia	Mental Mental arked o	5	Unknow	n					Delo				
Maryland	W E _ 3		. tnformant's No	eme/Relationship	p (Type, Print)		19b. Meiling	Address (Stree	t and Number or	Rural Route Numb	er, City or Town,	, State, Zip (	Code) 2078/4
	CENL		Marqui	ta Sellm	nan/Daughte			Riverdal		#203, Ne			
ore	of Heal of Heal fram 2 r other	20a	Method of Dis	position		20b. Plac	ce of Dispos	ition (Name of atory or other pla		Date	20c. Location	- City or Tow	m, State
E		46		☐ Cremation 3 5 ☐ Other (Spe	I □Removal from State ocify)	10		Veteran		08/31	Chaltan	ham 1	Maryland
altimore,	교투원증.	21.		uneral Service Lic	**	, 1141	22.	Name and Addre	ess of Facility			illaill, i	Maryrand
B	Depa Impo any I		IA.	Λ	0 -	+.				ERAL HOME			
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		1	shock, or hea	int failure. List or	omplications that caus nly one cause on each	line.	DO NOT BINE	i ilie iliooe oi uyi	ng, audi ba dan	nac or respiratory a	1630,		Intervel Between Onset and Death
	Physician /Medical	Imr	nediate Cause	/Final	0+1	/	0.	4 /		p	7	1	
	Examiner	dis	ease or condition	on	0. ITUM	4050	fere	1/2 0	Andio	viscula	v Vise	ease,	
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	be assecuted sician and burishtransit				b								
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9	0 0 0		quentially list co ny, leading to in se. Enter Unde use (Disease or	enditions, nmediate erlying injury	b	Due to (or a	s a consequ	ence of):				t t	
928	physici the bu		quentially list cony, leading to in se. Enter Under use (Disease or initiated events ulting in death)	5	C	Due to (or a						t	
× 68760	rificata ng phys as the	Cau	initiated events	5	c							t t	
	rificata ng phys as the	Cau	initiated events	5	c							1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
Box	rificata ng phys as the	Cau	(initiated events ulting in death)	s Last	b	Due to (or as	s a consequ	ence of):	ven in Part I.	23b. Did	tobacco use co	t t t t t t t t t t t t t t t t t t t	the cause of death?
	rificata ng phys as the	Cauthaires	II. Other signif	Last	s contributing to death	Due to (or as	s a consequing in the uni	ence of): derlying cause gr					the cause of death?
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P.O. Box	es that the death certificate igned by the attending physical for use as the by Physician/Madic	Cau thai resi	II. Other signif	Last	s contributing to death	Due to (or as	s a consequing in the uni	ence of): derlying cause gr		1 🗆		3☐ Probe	re autopsy findings
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P.O. Box	e law requires that the death certificate has been signed by the attending physic 2 should be detached for use as the mbleted by Physic lan/Media	Cau thai resi	II. Other signif	Last	s contributing to death	Due to (or as	s a consequing in the uni	ence of): derlying cause gr		1 🗆	Yes 2□ No an autopsy omed?	3 Probe	ably 42 Inknown re autopsy findings lable prior to lipitation of cause
P.O. Box	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the Completed by Physician/Media	Cauthaires	Initiated events uiting in death)	East  Sicent conditions  Fud S  Dia ba	s contributing to death	Due to (or as	s a consequing in the uni	ence of): derlying cause gr		1 - 24a. Was perfe	Yes 2□No an autopsy med?  Yes 2□No	3 Probe	ably 42 Inknown re autopsy findings lable prior to spletion of cause eath?
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Vital Records, P.O. Box	Hooptial or Attending Physician: The law requires that the death certificate 4 hours after death. Funeral Director: After this certificate has been signed by the attending physical filled in by the funeral director, page 2 should be detached for use as the filleal Certification: To Be Completed by Physician/Media	Part 25.	Wes case referencement of Death of Neutrel 2   Accident 3   Suicide 4   Homicide	Ticant conditions  To d S  DPA DA  red to medical  No  h  5   Pending investigal  6   Could no determine	Hospital: 12 Inpa 28a. Date of Ir (Month, L) to building,	Due to (or as but not resulting the substitution of the substituti	s a consequence of the unit of	ance of):  derlying cause given a control of the co	26. Place of I	24a. Was performed to the control of	Yes 2 No an autopsy primed?  Yes 2 No one) dence 6 Ott thow injury occur win, State)  cause(s) and mi	3 Probe  24b. Wer available common of de 1 prober (Specify) med  ber or Rural	re autopsy findings lable pnor to upletion of cause eath?  Yes 2 No  Route Number,
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Vital Records, P.O. Box	No Hospital or Attending Physician: The law requires that the death cardificate no.4 hours after death.  No Funeral Director: After this certificate has been signed by the attending physiciety filled in by the funeral director, page 2 should be detached for use as the edical Certification: To Be Completed by Physician/Medic	Cathal residual resid	Wes case referexaming?	Ticant conditions  Ticant condit	Hospital: 12 Inpa 28a. Date of Ir (Month, L to be ed 28e. Place of building,  Physician: To the besis	Due to (or as but not resulting the substitution of the substituti	s a consequence of the unit of	ance of):  derlying cause gives a constant of the constant of	26. Place of I her: 4 Nursin ry at rk? 1 Yes 2 No me, date and place popinion, death or se number	24a. Was performed by the second of the seco	Yes 2 No an autopsy primed?  Yes 2 No one) dence 6 Ott how injury occur  Street and Numb wn, State)  cause(s) and me date and place, 29d. Date signe	3 Probe  24b. Wer avai com of de 1 — her (Specify) med  ber or Rural anner as ste and due to	Route Number,  the cause(s)
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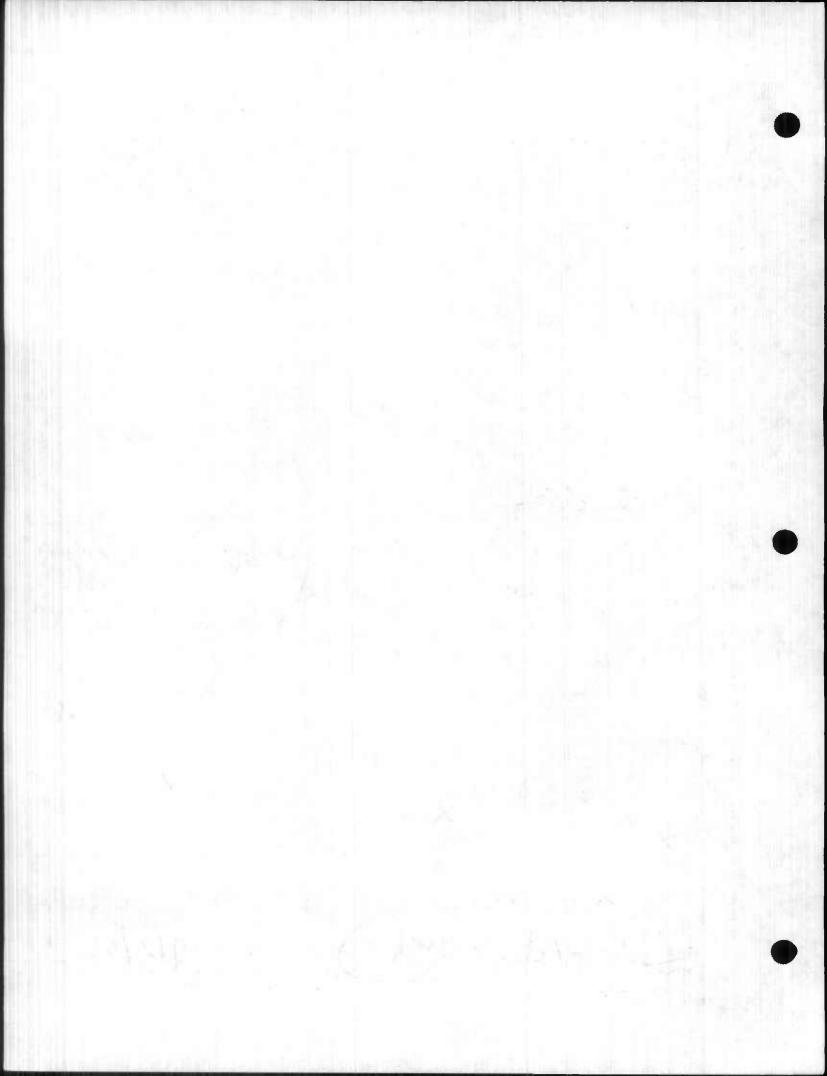
State of Maryland / Department of Health and Mental Hygiene 00 00 100

			C	ertifica	te of E	Death		Reg. No.	10	651	0 /		
	1. Decedent's Name (First, Middle, Las	it)		17.1			2. Date of De		Year	3. Tima			
Physician /Medical	Julian L. Smit	h, Sr.		-			Hugus	+ 39 a	2000	4:3	10 AV		
Examiner	4a Facility Name (If not institution, give						Location 6 Deat	,					
	Doctors Community	•				anham			e Geo				
uneral rector	5. Social Security Number 8. S. 579–12–7133	7. Age (fi	n yrs. last birthda 81 Yrs.	Months	Days	If Under 24 Hrs Hours   Min		th 19, Year) 1919	9. Birthpl Coun Mary I	lace (State try) and	or Foreig		
	Usuel Residence of Decedent	1.4	Oc. City, Town or	1						Od beside t	D/a . 1 3 4-		
data d	10a. State 10b. County									0d. Inside (	s 20th		
be notified	Maryland Prince G	eorges	Oxon Hil					10 00 11			75-00		
	10e. Street and Number 5803 Chrisfield C	ourt			0745			10g. Citizen of 1	What Coun	try r			
Examiner must Examiner must I by Funeral	11. Maritel Status  1 Never Married 20 Married 3 Widowed 4 Divorced	12. Wes Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:	or in U,S.	3. Was Dece If Yes, spo 1 Yes		spanic Origin? ( n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	Bla	ce - America ck, White, o y: Blac	etc.			
fred fred	15. Decedent's Ed (Specify only highest gra-		16a. Dec	cedent's Usi	ual Occups	tion	ndkina	16b. Kind of B					
r, the Medical Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		rity	_	uring most of wo	and the second	Washing Company		as &	Ligh		
Be C	17. Father's Neme (First, Middle, Last)	Barrier A. F. Co.				18. Mother's Na	me (First, Middle	, Maiden Suman	ne)				
9 0	Julian Leroy Smit	h				Mary Al	berta Wi	lliams					
-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Ma	iling Addres	ss (Street a	nd Number or F	lural Route Numb	er, City or Town	, State, Zip	Code)			
	Ida W. Smith/Wife		same	as i	tem 1	.0							
otho	20e. Method of Disposition		20b. Place of Dis	position (Na	ame of	- I	Date	20c. Location	- City or To	wn, State			
8		Hellingel Itolli State					/2/2000	Domfrot	Man	1000	247		
in in	4 Donation 15 Other (Specify) St. Joseph C.C. Cemetery 9/2/2000 Pomfret, Mar  21. Signature of paral Service Lipships 22. Name and Address of Fecility												
emp emp emp	22. Name end Address of Fecility  George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745												
	23a. Part1 Enter he disease, or comp	slications that caused the	death Donal	5160 C	xon I	Hill Rd.	, Oxon I	Hill, MD	2074	5 Approxima	ate		
	21a Parti Enter he disease, or companded, or heart failure. List only	one cause on each line.	Joann. Do nor e	110 110	ou or uyan	,, 500,740,04,010	io or rospiratory c		1	Interval Be	neewte		
cian lical	Immediate Cause (Final	D	0 1 100 0	w : a						1.1	1		
iner	disease or condition resulting in death)										days		
ē 🔣		Du	e to (or as a cons	sequence of	):								
Examiner		b							- 1				
Exami	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Du	e to (or as a cons	sequence or	):								
	Cause (Disease or injury that initiated events	c											
edical	resulting in death) Last	Due	e to (or as a cons	equenca or)	):				1				
5		d											
cian/							1						
Physic	Part II. Other eignificant conditions co	entributing to death but n	ot resulting in the	underlying	cause give	n in Part I.		tobacco use co					
4	Urinary I	ract Inf	ection	, U	1400	tensio	ואו	Yee 20 No	3 Prot	bably 4	Unknov		
Completed by Physician/					11		24a. Was	an autopsy ormed?	ava	ere autopsy ailable prior mpletion of death?	rto		
mp											3		
rector, page							10	Yes 20 No	1	☐Yes 2[	□ No		
director.	25. Was case referred to medical examiner?	Hospitai:			OA Othe	Mr.	ath (Check only						
P P	1 Yes 2 No	1 Lanpatient	2 ER/Outpat		NA	4 Huising	Home 5 Res			y)			
funeral di	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye	28b. Time Injur		28c. Injury Work	? ? fes 2 No	280. Describe	how injury occur	rred				
	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		- At home, farm, Specify)			165 20110		(Street and Num. wn, State)	ber or Rura	Il Route Nu	mber,		
completely filled in by Medical Certifi	29a. Certifier 1 Certifying Phyone 2 Medical Example 1	valcian: To the best of m liner: On the basis of ex and manner stated	amination and/or	ath occurred investigation	d at the tim	e, date and place inion, death occ	e, and due to the curred at the time	cause(s) and m date and placa,	anner es s' , and due to	lated.	(s)		
To the Funeral Director: completely filled in by the Medical Certifical	29b. Signature and title of certifier	and mariner stated		29	9c. License	number		29d. Date signe	ed (Month.	Day Year			
8 -	* Xlorge C.	200 'S	wh			9550			29-				
0)	30. Name and address of person who co	completed cause of death	h (Item 23a) (Typ	e, Print) 485	o Fe	rbes Bl	ud. cax	ham, w	d z	0706			
State	31. Dete filed (Month, Day, Year)												
State	George C. H	completed cause of death	1. M.D.	e, Print) 485	o Fe	rbes Bl	ud. Cax	ham, w	d z	0706	A		



State of Maryland / Department of Health and Mental Hygiene

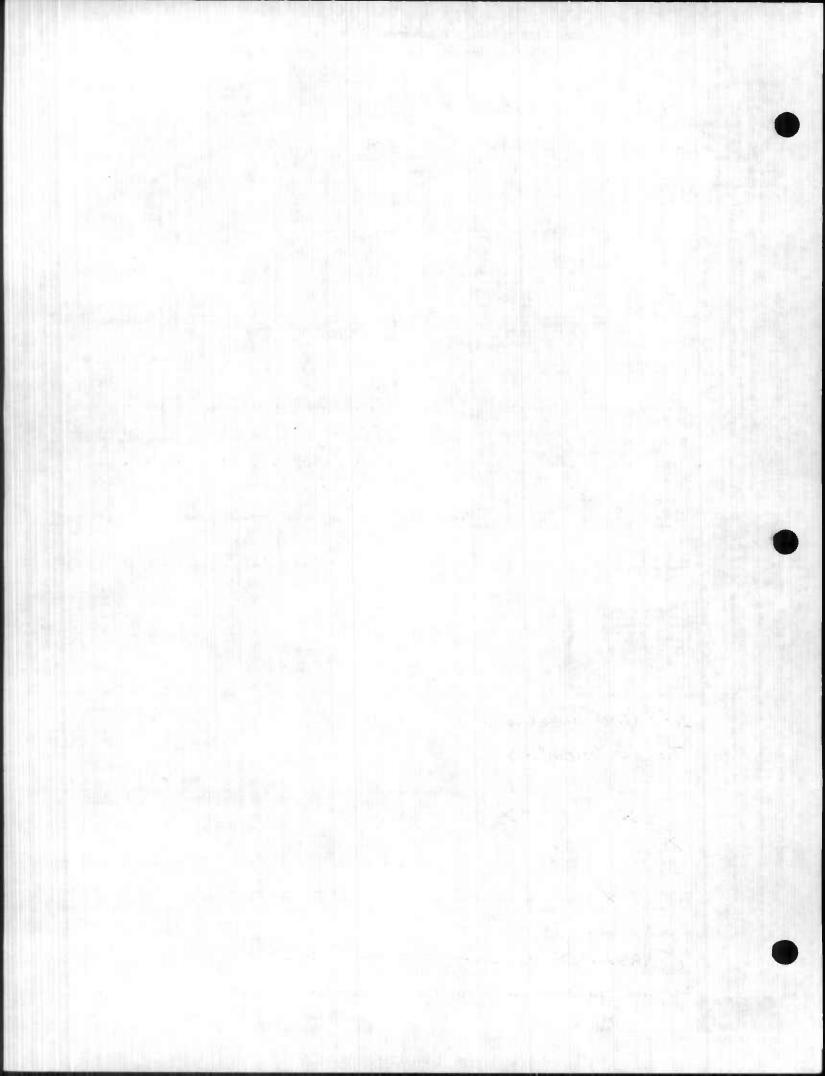
	Certificate of Death	Reg. No.
	Decedent's Name (First, Middle, Last)	2. Data of Death Month Day Yaar 3. Tima of Death
Physician /Medical	James Charles Samarra	September 1 2000 5:16PM
Examiner	4a Facility Name (If not institution, give street and number)  4b. City, Town	, or Location of Death 4c. County of Death
	Civista Medical Center LaPlate	
Funeral		Min. (Month, Dey, Year) Country)
Director	173-18-9098	01-31-1921 Pennsylvania
pug *	Usuel Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location	10d. Inside City Limits
with the Maryland a or 28a-f show Les notified at		1 □ Yas ŽÇNo
the N	MarylandPrince Georges   Temple Hills  10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
ifer death with the Marylar r ferms 23e or 28e-f show the mast te motified at Funeral Director		
ms 23	8601 Temple Hill Road   20748     11. Marital Status   12. Was Decedent Ever in U.S. Armed Forces?   13. Was Decedent of Hispanic Origin If Yas, specify Cuben, Mexican, F	United States 17 (Specify Yes or No- 14. Race - American Indian,
her dea	1 Never Married 2 Married Wayes 2 No 1 9 / 2 _	Puerto Rican, atc.) Black, White, etc.
- 0 -	3 No Specify:  3 No Specify:  Year or Detes: 1943	Specify: White
natural.	15 Decedent's Education 16e, Decedent's Usual Occupation	16b. Kind of Business/Industry
	(Specify only highest grede completed)  (Giva kind of work done during most of life. DO NOT usa retired)  (Giva kind of work done during most of life. DO NOT usa retired)	f working
r than	12 Artisan	Stain Glass Studio
d other svent, a Be Cc	17. Father's Name (First, Middle, Last)  18. Mother's	Name (First, Middle, Maiden Surneme)
marked o	Pete C. Samarra Marga	rite Gaillot
and h	19a. Informent's Neme/Relationship (Type, Print)  19b. Meiling Address (Street end Number of	or Rural Route Number, City or Town, State, Zip Code)
27 T	Charles E. Samarra/Son P.O. Box 210, Mar	bury, Maryland 20658
	comptant commetant or other place	Date 20c. Location - City or Town, State
Int: H	1 XBuriel 2 Cremation 3 Remove from State 4 Donetion 5 Other (Specify)  Maryland Veterans Cemetery	2000 Cheltenham, Maryland
Department of moortant: If any injury or ance.	21. Signeture of Funeral Service Liganize 22. Nema and Address of Fecility	
8 E 2 8	MOO668 4370 Howthorne	al Home, P.A. 20640 Road, Indian Head, Maryland
	23a. Pert1. Enter the database, or complications that caused the deeth. Do not enter the mode of dying, such as ca shock, or heart miure. List only one cause on each line.	ardiac or respiratory arrest, Approximete Intervel Between
hysician	Short, of respect to the control of	Onset and Death
/Medical	Immediate Ceuse (Finel disease or condition	isease. X years
xaminer	resulting in death)	) 0
in end fel-transit Examiner	- Condiale History	× Hem
trans	Sequentially list conditions, Due to (or as a bensequence of):	1 1 2 x red
lan kuriat	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	med Vesell District
physician end is the burial-transit edical Examir	thet initiated evants  resulting in death) Lest  Due to (or as a consequence of)	
D 0		
cate has been signed by the attendin page 2 should be detached for use Completed by Physician/R		
y the attention to the sched for u	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i.	23b. Did tobacco use contribute to the cause of death?
ed by the deteched		1 Yee 2 No 3 Probably Unknow
signed be der		24a. Wes en eutopsy 24b. Were autopsy findings
should should leted		24e. Wes en eutopsy performed?  24b. Were autopsy findings available prior to completion of cause
has b		of death?
page Com		1 Yes 2 No 1 Yes 2 No
director, pag	axaminer?	f Death (Check only one)
0 0	1 Yes 28 No Hospital: 1 Inpatient 2 NER/Outpatient 3 DOA Other: 4 Nurs	ing Homa 5 ☐ Rasidance 6 ☐ Other (Specify)
h. After this certific funeral director, tion: To Be	27. Menger of Death 28a. Dete of Injury 28b. Time of 28c. Injury at Work?	28d. Describe how injury occurred
death. ctor: A y the fu	Accident investigation M 1 Yes 2 No	
is sher death.  al Director: After to led in by the funeral Certification:	3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify)	28f. Location (Street end Number or Rural Routa Number, City or Town, Stele)
within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:		
in 24 hours he Funeral pletely filled edical C	29a. Certifier Check only Contifying Physician: To the best of my knowledge, death occurred at the time, date end process of examinetion and/or investigation, in my opinion, deeth	
within 24 hours To the Funeral completely filled Medical C	one) and manner stated.	
To the com	29b. Signature and title of pertiller	29d. Dete signed (Month, Dey, Year)
	1 20629	7/2/00
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11345 Pembr	ooke Square, Suite 103
	George H. Wathen, M.D. Waldorf, Ma	ryland 20603
State	31. Dete filed (Month, Dey, Year) 32. Registrar's Signetura	



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State of Maryland / Department of Health and Me	ental Hygiene		29169
Certificate of Death	Reg. No.		best de la

			Ctate of Mai		ertificate of			Reg. No.	0 - 6 2	. 0 .
	LINE	1. Decedent's Name (First, Middle, L.	nst)	_	/	11163	2. Dafe of De		Year 3. Time	e of Death
_	Physician /Medical	Billy	Vallace	Sny	1 dek		Augus	17,20	15	pm
	Examiner	4a Facility Name (If not institution, gi	ve street and number)	111	0 /	4b. City, Town, or Lo		4c. County	of Death	1
- XI		University of MA	Ry wand MI	dical S	VStom	W. confidencial Co. S. C.	one		imore C:	
Fu	uneral		Sex 1XXXM 2□ F	In yrs. lest birthd	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	th y, Year)	9. Birthplace (Sta Country)	te or Foreign
Dii	rector	217-64-2932	AN 2LI	46 Yrs			July 8	, 1954	Maryland	
P	1	Usual Residence of Decedent  10a. Stata 10b. County	1	Oc. City, Town or	r Location				10d. Inside	e City Limits
la de	of all									res 2□No
2	28a-fs potified ector	MD Harfor	<u>ra</u>	Aberde	10f. Zip Code			10g. Citizen of W	fhat Country?	
- 6	Die Die	413 Dawn Ct.			21001			U.S.A		
1	iner must iner must Funeral	11. Marifal Status	12. Was Decedent Eve	er in U.S. 1		dispanic Origin? (Spe	ecify Yes or No		- American Indian	١,
020	if, or the complex by Fun	1 Never Married 2CMarried 3 Widowed 4 Divorced	Armed Forces?  12 Yes 2 No If Yes, Give Year or Dates:		3. Was Decedent of In If Yes, specify Cub. 1 ☐ Yes 2 No		Rićan, etc.)	Specify:	White	
21215-0020 d within 72 hours at plane.	ted bet	15. Decedent's E	ducation	16a. De	ecedent's Usual Occup	pation		16b. Kind of Bu	siness/Industry	
215	Medi plet	(Specify only highest gi	rade completed)  Collega (1-4or 5+)	(G	ive kind of work dona a. DO NOT use retire	during most of worki d)	ing			
21 Parit	comple	12	0		vil Service	e		U.S. Go	vernment	
D SE	d othe event. Be C	17. Father's Name (First, Middle, Las	()			18. Mother's Name	(First, Middle,	Maiden Sumam	e)	
/an	To die	Richard W. Snyde	er			Erna Ger	rta Boy			
Maryland		19a. Informant's Name/Ralationship	(Type, Print)	19b. M	ailing Address (Street	and Number or Run	A Route Number	er, City or Town,	State, Zip Code)	
N 50	27 S	Theresa A. Sny	yder	4	13 Dawn Ct	., Aberde	en, MD	21001		
Ore of He	16	20a. Method of Disposition  Durial 2 ☐ Cremation 3	The result from Contra	20b. Place of Di cemetery, o	sposition (Name of crematory or other pla-	сө)	Date	20c. Location -	City or Town, State	•
Limore Pages 1 Iment of Ha	10 0	4 Donation 5 Other (Spec	ify)	Harford	Memorial	Gardens 8	/22/00	Aberdee	en, MD	
Balt pemit.	any inju	21. Signature of Funefal Service Lice	risee 2		22. Name and Addre			e, P.A.		
		220 Part Enter the disease or on	polications that countd th	2 death Donat	Aberdeen,			rroet	Approxi	mete
Phys	alaian .	23a. Part1. Enter the disease, or cor shock, or heart failure. List only	one cause on each line.	o douth. Do not	one ma mode or dyn	ng, scorr as cardiae	or respiratory a		Interval	Between nd Death
	sician edical	Immediate Cause (Final	-1./	/	1/-	) '/	1			,
Exa	miner	disease or condition resulting In death)	= FIECTRO			resocia fi	ou		151	nutes nutes
\$	<u>ē</u>		Linus	e to (or as a con	isaquance or):				Com	
petn	n and ial-transit Examiner	Conventially list availations	b. Jypovo	emice le to (or as a con	sequence of):				Milliam	nures
		Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events	In. Le 1		/				Com	· Los
68760, ficate be a	the buria	Cause (Disease or Injury that initiated events	c. Mure P	e to (or as a con-	nage sequence of).	1			70 mis	wies
	0 0 d	resulting In death) Last	Ω.	1.51	[10.1	Times			Coho	100
Box auth cen	for use a		d. Nemouly	01/21	+ Kenas	/umor			100100	470 3
Geat	od for	Part II. Other significant conditions	contributing to death but r	not resulting in th	e undarlyling causa giv	ven in Part I.	23b. Did	tobacco uss cor	tributs to the cau	es of death?
- =	pate has been signed by the attending, page 2 should be detached for use. Completed by Physician/M	15/20017	1/.	vena	1		10	Yes 2000	3 Probably	4 Unknown
S, the	d by P	Let & Kurul run	nor with	vena	CAUGI					
prd duin	should t	Tumor Thron	6.				24a. Was	sn autopsy	24b. Wara autop availabla pr	ior to
law re	2 sh	- rumore (nko)	2005	-					completion of death?	of cause
H all	age of or						10	Yes 20 No	1 Yes	2 No
is is	is certificate has director, page 2 To Be Comp	25. Was case referred to medical				26. Place of Deat	h (Check only	ona)		
of Vita	00	examiner?	Hospital: Inpatiant	2 ER/Outpa	itient 3 DOA Oti	her: 4 Nursing Ho	me 5 Rasi	danca 6 Oth	er (Specify)	
	er th	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Tim		ry at	28d. Dascribe	how injury occurr	ed	
Vision Attending or death.	he fu	2 Accident investigation	on			Yas 2 No				
VISION AND AND AND AND AND AND AND AND AND AN	al Director: After the in by the funeral Certification:	3 Suicide 6 Could not determined	28e. Place of Injury building, etc. (	- At home, farm, 'Specify)	, street, factory, office		28f. Location ( City or To	Street and Numb wn, Stata)	er or Rural Route I	Vum <i>ber</i> ,
D of a										
DIVISION To the Hospital or Attending within 24 hours after death.	To the Funeral Director: After thi completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one)  Certifying P  Certifying P  Certifying P	hysician: To the best of r miner: On the basis of ex and manner state	camination end/o	eath occurred at the ti r Investigation, In my o	me, date and place, opinion, daath occurr	and due to fha red at the time,	cause(s) and ma date and place,	nner as stated. and due to the cau	se(s)
Toth	Me We	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed	Month, Day, Yes	ir)
		100	1		POO	1785		8-17-	2000	
	/	30. Name and address of person who	completed cause of deal	th (Item 23a) (Tv		, - )		0		
(	5	DEBORAH GUASSIN				MORE M	15 212	21		
	State	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	4	11	201 44			
F	Registrar	AUG 23		wa /	J. spa	KS				

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene

			C	entitica	ite of	Death		Reg. No.			
hysician	1. Decedent's Name (First, Middle, La						2. Date of I Month	Death Day	Year	3. Tima of Deat	
/Medical	Concepcion		aitano				Augu	st 24,	2000	9:10AM	
xaminer	4a Facility Name (If not institution, git						or Location of De		ounty of Death		
	5601 Helmont Dri		the constant brints	tout If Hor	ler 1 Year	Oxon Hi				eorge's	
rai or		Sex 7. Age 7. Age 81	(In yrs. last birtho	Month		Hours M	in. (Month,			place (State or Fore	
	Usual Residence of Decedent	A   01					June	24,1919	Umar	ac, Guam	
	10a. State 10b. County		10c. City, Town o	r Location						10d. Inside City Lin	
oto	Maryland Prince	George's	Oxon	Hill						1 ☐ Yes 2 ☐ X	
Directo	10e. Street and Number			10f. 2	Zip Code			10g. Citizer	of What Cou	intry?	
	5601 Helmont Dri	.ve			2074	45		USA	4		
Funeral	11. Mantal Stetus	12. Wes Decedent E Armed Forces?	ver in U,S.	13. Was Dec	cedent of H	lispanic Origin? an, Mexicen, Pu	(Specify Yes or ento Rican, etc.)	No- 14.	Race - Ameri Black, White,		
by	1 ☐ Never Married A Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2XXX If Yes, Give Year or Dates:	0	_	2XXN0	Specify:				n/Chamor	
Completed	15. Decedent's E	ducation	16a. D	ecedent's Us	sual Occup	eation during most of a	working	16b. Kind	of Business/Ir	ndustry	
nple	Etementery/Secondary_(0-12)	College (1-4or 5	+)			d)	No. Williams				
Cor	5th		H	omemak	er				Home		
e	17. Father's Name (First, Middle, Last  I. Hamamoto	")					Name (First, Midd		mame)		
5							Infana				
	19a. tnformant's Name/Relationship						Rural Route Nur	nber, City or T	own, State, Zi	p Code)	
	Jose S. Taitano/	Husband	20b. Place of D	ame as		n 10	Date	200 1000	tion - City or T	own State	
	20a. Method of Disposition 1    Burial 2 □ Cremation 3 [		cemetery,	crematory o	r other pla				17.1	1	
	4 Donation 5 Other (Speci		Arling						-	Virginia	
	21. Signature of General Sawice Lice	0090		Georg	e P.	Kalas F	Funeral Home, P.A.				
	23a. Part I. Enter the disease, or con	Hill, N	ld. 207	Approximate							
an	shock, or heart failure. List only	one cause on each lin	6.	eriter the fit	oue or ayıı	ig, soon as cert	and of respiratory	y arrost,	app.	Interval Between Onset and Death	
	Immediate Cause (Final	Lune	Cancer							2 yrs.	
al er	disease or condition resulting in death)										
e	Due to (or es e consequence of):										
Examiner	Sequestially list conditions	b	Due to (or es a co	nsequence o	of):				1		
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edicai	Cause (Disease or Injury that initiated events resulting in death) Last	c	Due to (or es a cor	nsequence o	f):						
Med	resulting in death) Last								1		
		<b>Q.</b>									
Physician	Part It. Other significant conditions	contributing to death bu	t not resulting in t	he underlyin	g cause giv	ven in Part I.	23b. D	ld tobacco us	e contribute	to the cause of de	
Ph	Lettistica and the						1	□ Yes 2□	No 3□ Pro	obably 4 Vunkr	
by							0.45 144	la a a autono	24h V	Vere eutopsy findin	
Completed							24a. W	as an autopsy erformed?	a	veilable prior to ompletion of ceuse	
-idu									0	f death?	
							11	□ Yes 2X	No 1	☐ Yes 2☐ No	
Be	25. Was case referred to medical axaminer?	Hospital:			DOA Ott	205	Deeth (Check on				
10	1 Yes XXNo	1 ☐ Inpatie	-		DUA	4 LI NUISIII	g Home 5 N R	esidence 6 [ be how injury o		eify)	
rlon	Natural 5 ☐ Pending	(Month, Dey			Wo	rk? Yes 2 □ No					
lica	3 Suicide 6 Could not b	De Otean of lair	ıry - At home, fam	n. street, fact			28f. Locatio	n (Street and I	Vumber or Ru	rel Route Number,	
Certification:	4 Homicide	building, etc	. (Specify)				City or	Town, State)			
edical C	(Check only 2 Medical Exa	hysician: To the best o miner: On the basis of	f my knowledge, o	deeth occurre	ed et the ti	me, date end plo ppinion, deeth o	ece, end due to t	he ceuse(s) ar ne, dete end p	nd manner as	stated. to the ceuse(s)	
Med	one)	and manner sta						4			
~	29b. Signature and title observation	11			29c. Licens		F0/6		signed (Month		
	XW	i de	4		(Pa.)	MD 051	.5242	Augus	st 24,2	000	
	30. Name and address of person who								77		
	John A. Poremba,			Medic	al Ce	enter An	drews A	ir Forc	e Base	, Md.207	
tate	31. Date filed (Month, Day, Year)	22. Registra	r's Signature	1	1						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death 17,2000 Physician TURNER, August **JESSE** JR. 2:30AM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Civista Medical Center La Plata Charles If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 10-26-36 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Months Days Hours 10 M 20 F WAVERLY, VA 231-42-8894 63 Yrs. **Usual Residence of Decedent** 10b. County 10c. City, Town or Location 10d. Inside City Limits MD WHITE PLANE Director CHARLES Yes 2□No 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 20695 10622 RIVA PLACE U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give A
Year or Dates: 1 Never Married 2 Merned 1 Yes 25 No Specify: BLACK Specify: P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A SELF EMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JESSE TURNER CERRIE 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JESSE TURNER III SON 8571 ENOCHS DRIVE, LORTON VA. 22079 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 8-23 1 Surial 2 □ Cremation 3 □ Removat from State WAVERLY, VIRGINIA WAVERLY CEMETERY 4 ☐Donation 5 ☐Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility
TAYLOR'S FUNERAL HOME 1722 NORTH CAPITOL ST. NW WASH., DC the that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Deeth monany Unest Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last p (or as a consequence of) Roels Physician/Medical 00 Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown 81,00 þ Completed 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? 2 24% 1 Yes 1 Yes 2 No Be 25. Was case referred to medicat axaminer? 26. Place of Death (Check only one) 1 Yes 2 Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Naturat 2 Accident 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and the of curtifier 29c. License number 29d. Date signed (Month, Dey, Year) D-46979August 17, 2000

To the Hospital or Attandil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

**Funeral** 

Director

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Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 Is marked other any Injury or other traumatic avent pages.

Physician /Medical

Examiner

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Box 68760.

P.O.

Records,

Division of Vital Attanding Physician:

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Maryland

Baitimore.

Registrar

Collins P. Sein, MD 605 East Charles Street, La Plata, Md 20646 31. Date filed (Month, Day, Year) 32 Registrar's Signature AUG 2 2 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene

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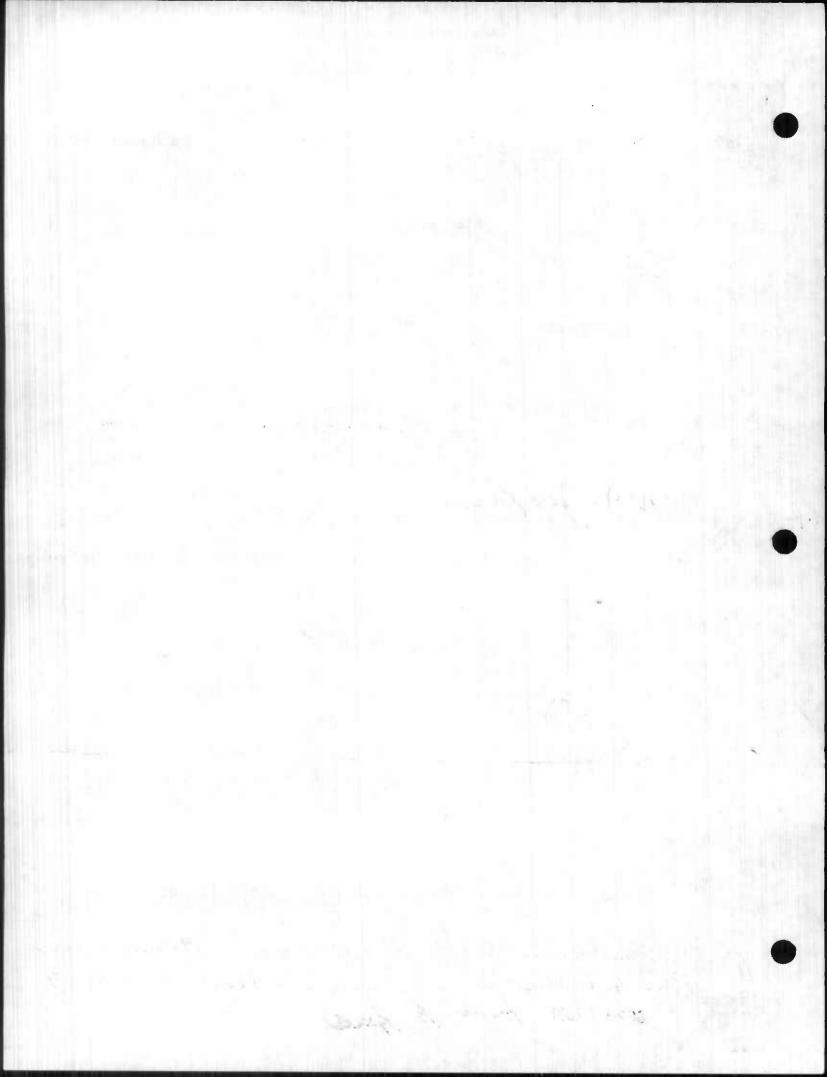
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Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health end Mentel Hygiene.  Department if item 27 is marked other than "natural", or items 23s or 28s-1 show any Injury or other traumatic event, its Wider Expression to the propriet and once.
	Physician
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Division of Vital Records, P.O. Box 68760,	after death.  In or Attending Physician: The law requires that the death certificate be associted to the standing physician and in physician and in by the funeral director, page 2 should be detached for use as the bunal-transit are in

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DHMH 16 Rev 6/95

Registrar



AMEND	ITI	EM # 5 Cecil Co	. 09/7/00		•		Mental Hyg	g. No.	0 2	3. Time of Death
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1 and 1 Health em 27		Philip S. Lowe /	nephew		Sylvan R  Disposition (Neme	oad, North		ryland 20c. Location -		
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tmert:		4 □ Donation 5 □ Other (Specif		Sunnyr		rial Park	2000	Crisfie	ld, Ma	ryland
poemit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If hem 27 is marked other than any injury or other traumatic event, the interpretations.		21. Signature of Funeral 89 vice Licer			Crouch I	ddress of Fecility 'uneral Hor est, Maryla	and 21901		in Str	reet,
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ysician: The lav s cartificate has director, page 2							1 U Y	es No	10	Yes 2 No
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State of Maryland / Department of Health and Mental Hygiene

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Funeral		5. Social Sacurity Num	per 6. S		-	. lest birthday,	If Undar 1 Yaa Months Days					place (State or Foreign
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though	Director	10e. Street and Number					10f. Zlp Code			10g. Citizen of	What Coun	itry?
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INST. INS	Funeral	11. Marital Status	1200	12. Was Dece	dent Ever in	U,S. 13.	Was Dacedant of	Hispanic Origin?	(Specify Yes or Narto Rican, etc.)	o- 14. Rac	ce - Amaric ck, White,	an Indian,
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CORT	9	15	Decedent's Ed	lucation		16a. Dece	dent's Usual Occi	pation		16b. Kind of B	usiness/inc	dustry
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any injury or other tra	1	20a. Method of Dispost	tion		20b.	Place of Disp	osition (Neme of		Deta =	20c. Location	- City or To	wn, Stata
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9 6	5	27. Manner of Death Natural 5	Pending		f Injury n, Dey Year)	28b. Tima o Injury	W		28d. Describe	how injury occur	red	
ficat	Icar		investigation ☐ Could not be		of Injury - At h	ome farm at	M 1[	Yes 2 No	26f. Location	(Street and Numi	her or Rura	I Route Number
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completely filled in by the funeral	200	29a. Certifier 10 (Check only 20 one)	Certifying Phy Medical Exam	rsician: To the I	sis of examin	owiedge, deet ation and/or in	n occurred at the t vestigetion, in my	lme, dete and ple opinion, death oc	ce, end due to the curred at the time	cause(s) end ma , date and place,	anner as st end due to	ated. the cause(s)
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		30. Name and address	of person who	completed cause	of death (Ite	m 23a) (Tvpa.	Print)	, ,		Johnso		1000
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								Certificate	of Death	7	1	Reg. No.	0	6.0116
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Examiner			chester			4.1	1		Carr	nbridge	9	Dorch	neste	er
	5	. Social Securify		6. Sex		7. Age (In yr.		nday) If Under 1						
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or hom or hom miner or	1	Marital Status     Never Mar	rried 2☐ Man	ied	Was Dece Armed For I ☐ Yes If Yes, Givi	2 No	U.S.	13. Wes Deceder If Yes, specify  1 Yes 2			ty Yes or No- can, etc.)		ck, White,	etc.
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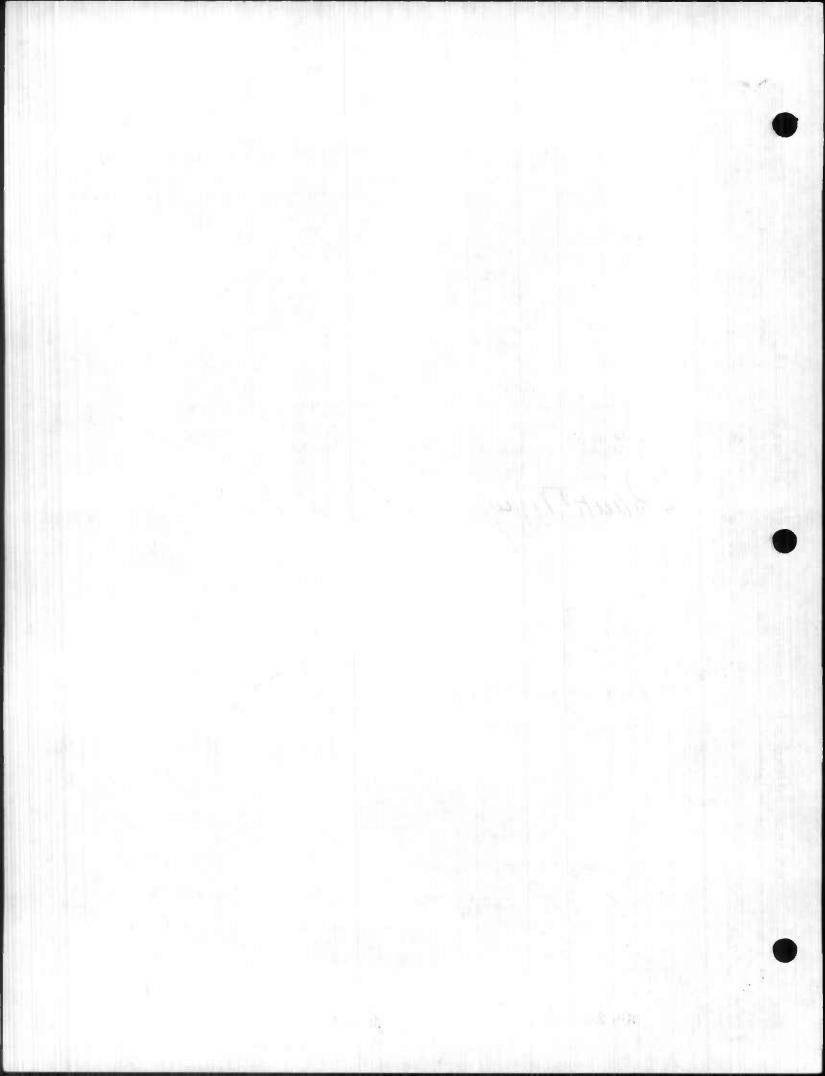
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State of Maryland / Department of Health and Mental Hygiene

					C	ertificate (	of	Death			Reg. N	lo.	U	63111
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	/Medica Examine	-	4a Facility Name (If not institution, giv	e street and number)	1			4b. City, To	wn, or L	ocation of Death	4	c. County	-	
	LAGIIIIIC	'	Doctors Communi	ty Hospital				Lanh	am			P. 1	G.	
-	Funeral		5. Social Security Number 6. S		n yrs. last birthda	y) If Under 1 Y				8. Date of Birt	h	. 1	9. Birthp	lace (State or Foreign
L	Director		479-90-3380 Usual Residence of Decedent	M 200 F	52 Yrs.	Months D	ays	Hours	Min.	8. Date of Birt (Month, Day June 16	, Yea	948	Anga	lace (State or Foreign
	Page 18		10a. State 10b. County		Oc. City, Town or								1	0d. Inside City Limits
	As-f sh diffed.	Director	Md. P. G	•	Glenda									1 ⊠ Yes 2 □ No
			10e. Street and Number 12402 Guinevere	Road		10f. Zip Co		20769			U	. s.		
020	a 6 ti	by runeral	11. Merital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	or in U,S. 1	3. Was Decedent If Yes, specify 1 ☐ Yes 2 ☒			gin? (Sp i, Puerto	ecify Yes or No- Rican, etc.)		Blac	ck, White,	rian
15-00			15. Decedent's En (Specify only highest gra	ducation ade completed)	16a. De	cedent's Usual O ve kind of work d . DO NOT use re	ccu	pation during mos	t of work	ing	16b.	Kind of Bu	usiness/Inc	
2121	d within	Compieted	Elementery/Secondery (0-12)	College (1-4or 5+) 5+	Ine	Nurse	etine	id)			H	lospi	tal	
Maryland 21215-0020	STEP STEP	99 0	17. Father's Name (First, Middle, Last Andrew Onwudiwe				i			e (First, Middle, ina Nwgb			10)	
Many	and 2 sho aith and N 27 is me is treume		19a. Informant's Name/Relationship (Dr. Ike Udejiofor	Type, Print) (Husban	31	illing Addrass (Si 402 Guin				Glendal		or Town, Md.		769
Baltimore	Pages 1 a ant of He nt: If Nam ry or othe		20a. Method of Disposition  1 ☑ Burlel 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif	Removal from State	cemetery, c	position (Name of rematory or other jiofor C	r pla		09	Date 9-05-00			City or To	
Balti	Dermit. Departm Importa any Inju	1	21. Signature of Funeral Service Licer		211	22. Name and A Bacon F	ur	neral	Home					
		+	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that coursed the	261	3447 14t	h	St.,	N.W.	Washin	gto	on, D	. C.	20010 Approximate
	Physician /Medical Examiner	iner	Immediate Cause (Final disease or condition resulting in death)	. Meta		covai							1	Onset and Death
0,	an end	Examine	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury	Du	e to (or es a cons	sequence of):						ne.	1-1	
Box 68760,	5 50	arymedical	Cause (Disease of Injury that initiated events resulting in death) Last	d.	e to (or as a cons	equence of):								
P.0.	5 00	by Physiciany	Part II. Other significant conditions of	ontributing to death but n	ot resulting in the	underlying ceus	e gi	ven in Part I	•	23b. Dld 1		2 XNO	ntribute to	o the cause of death? bebly 4 Unknown
Vital Records,	law requires es been sign 2 should be	Completed							_	24a. Was perio	an aut rmed?		av	ere autopsy findings allable prior to impletion of cause death?
æ	The law ate hes page 2	5								1)(	/es	2 No	1	Kes 2□ No
ta	certificate		25. Was case referred to medice!					26. Place	of Dea	th (Check only o	ne)			
>	5 00		examiner?	Hospitat:	2 ER/Outpat	ient 3 DOA	Ot	hor		ome 5 Resid		6 Oth	er (Specil	fy)
ou o	4 5 7		27. Menner of Death  1 Natural 5 Pending investigation	28a. Dete of Injury (Month, Day Y		of 28c.				28d. Describe I				
Division of		er mics	3 Suicide 6 Could not be determined	28e. Ptace of Injury building, etc. (3	- At home, farm, Specify)	street, factory, of	fice			28f. Location (S City or Tox			per or Run	al Route Number,
	Hospi 24 hou Funer stely fill	edical c	29a. Certifier (Check only one) 1 Certifying Ph	yelclan: To the best of m niner: On the basis of ex end manner stated	amination and/or	ath occurred at the investigation, in	ne ti	ime, dete en opinion, dea	d place, th occur	end due to the red at the time,	cause dete a	(s) end mo	enner as s	stated. the cause(s)
	Within To the comple	P	29b. Signature and title of certifier	Ma O		29c. Li	cen	se number			29d. C	ate signe	d (Month,	Day, Year)
			> Fynette	Theles,	MS	RE	1	5-06	00		8	12:	5/0	0
	(40)		30. Name and address of person who Lynette Su	ranne N	ichol.	e, Print) 5, 600	/	V We	olfe	Stree	+,	Bal	time	ore, MD
	State Registra		AUG 2 9 2000	32. Registrar's	Signature	Longe	/							2128

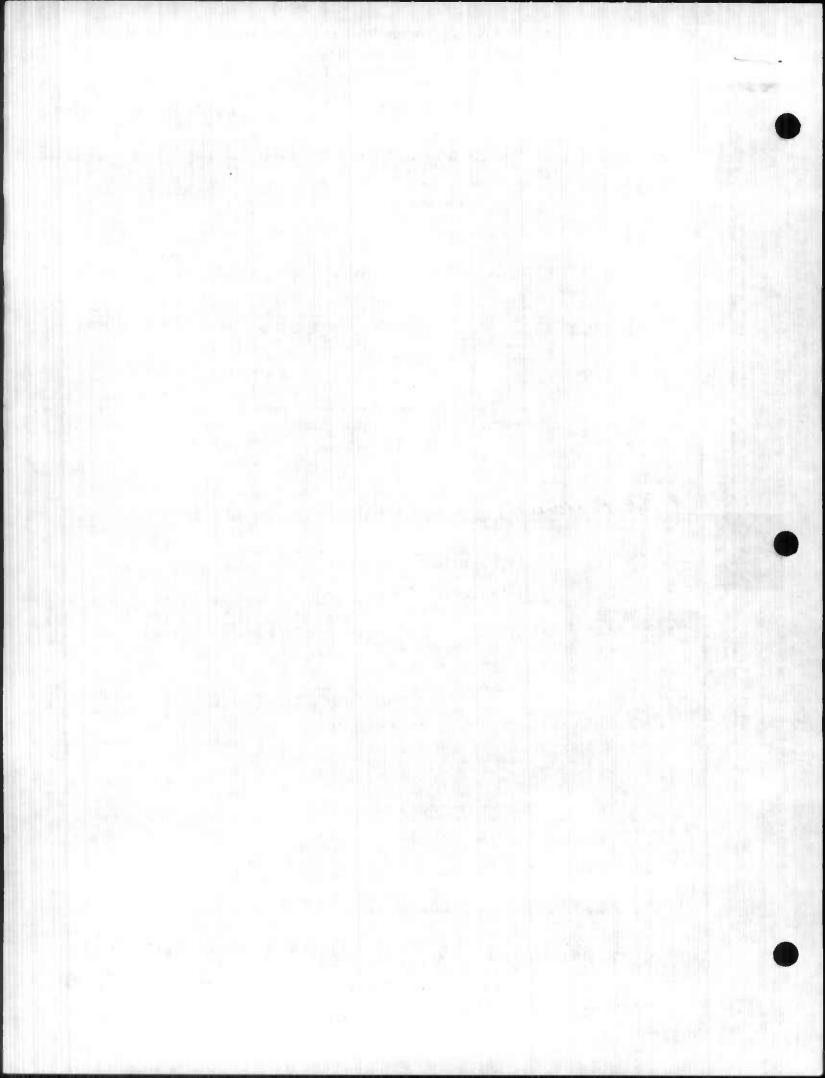
State of Maryland / Department of Health and Mental Hygiene

December Name of Park Modes, Law   Franz Alberto Vasquez   Alberto					(	Certificat	e of	Death		Re	g. No.	9	29.18	
Franz Alberto Vasquez  Franz Franz Alberto Vasquez  Franz Fr			1. Decedent's Name (First, Middle, La	ist)						e of Death			3. Time of Deeth	1
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Anne Arunde I Nedical Center    Post Color   C			4a Facility Name (If not institution, give					4b. City, Tow	vn, or Location of	of Death		ol Death	•	
Second Security Number   1	4		Anne Arundel	Medical Cer	nter			Anna	polis		Anne	Arun	del	
Use instance of Decident    Society	Funeral	5. Social Security Number 6. 5	Sex 7. Age	(In yrs. last birth			If Under 2	-	e of Birth	Year)	9. Birthp	ace (State or Fore	iign	
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Physician Medical Cause (Fine)  Physician (Medical Examiner)  Phys	Ē	Par	4 Donation 5 Other (Special	(y)	Metrop					2000	Alexan	dria	, Virgin	ia
Physician Medical Cause (Fine)  Physician (Medical Examiner)  Phys	3al	Manual And	21. Signature of Funeral Service Licer	nsee						DΛ				
Physician (Redical Examiner)  The property of		00240	Labort	Man		4739 I	Balt	imore	Ave., H	yatts	sville,	MD	20781	
Physician (Accided Examiner)  The file disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially lat conditions, at such large and conditions contributing to death but not resulting in the underlying cause given in Part I.  Due to (or as a consequence of):  a. Due to (or as a			23a Part Enter the disease, or com shock, or heart failure. List only	plications that coosed to one cause on each line	he death. Do no	enter the mod	te of dy	ing, such as o	ardiac or respir	atory arres	st,		Intervei Between	
Due to (or as a consequence of):    Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (or as a consequence of):   Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (or as a consequence of):   Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (or as a consequence of):   Due to (or as			1	10	1	1 1		1	Λ	4	1 1		Onset and Deeth	
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The state of the s	09/	sician burit	Cause. Enter Underlying Ceuse (Disease or injury	c		and a military to a						i		
The state of the s	89	phy is the	resulting in death) Last	D	ue to (or as a co	sequence of):								
Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.    1   Yes   2   No   3   Probably   4   Unknown				d										
24e. Wes en autopsy performed?  24e. Wes en autopsy performed?  24e. Wes en autopsy performed?  1   Yes   2   No    1   Yes   2   No    25. Was case referred to medical examiner?  1   Yes   2   No    25. Was case referred to medical examiner?  1   Yes   2   No    25. Was case referred to medical examiner?  1   Yes   2   No    26. Place of Death (Check only one)  27. Menner of Death   Work?    28. Describe how injury occurred    28. Describe how injury occurr		death of for	Part II Other eignificant conditions	vontributing to death but	not regulting in t	na undarhina c	euco n	iven in Part I	23	h Did toh	19000 HBB 000	tribute to	the cause of dea	th?
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25. Place of Deeth (Check only one)  26. Place of Deeth (Check only one)  27. Manner of Death 1   Yes   2   No  28. Date of Injury   1   Yes   2   No  28. Date of Injury   28. Place of Deeth (Check only one)  28. Place of Injury at Work?  28. Place of Deeth (Check only one)  28. Place of Injury at Work?  28. Injury at Work?	R	te ha age								1 ☐ Yes	2 No	10	Yes 20 No	
27. Manger of Death 1   Impatient 2   EN/Outpatient 3   DOA   DOA   Nursing Home 5   Residence 8   Other (Specify) 27. Manger of Death 1   Netural 2   Accident 5   Pending investigation 6   Could not be determined   28a. Date of Injury   M   1   Yes 2   No   28a. Date of Injury   At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, Stele)  29a. Certifier (Check only one)   29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.  29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print)   29c. License number   29d. Date signed (Month, Day, Year)   32. Registrar's Signature   31. Date litled (Month, Day, Year)   32. Registrar's Signature   32. Date signature   33. Date litled (Month, Day, Year)   32. Registrar's Signature   34. Date		tiffica for, p						26. Place	of Deeth (Chec	k only one				
27. Manner of Death	>	S 0 0		Hospital:	2 ER/Outp	atient 3 DC	DA O	ther				er (Specify	()	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State 31. Date Illed (Month, Day, Year)  32. Registrar's Signature	0	g Ph er thi neral		28a. Date of Injury	Year) 28b. Tir	ne of	28c. Inju	ury at	28d. De	scribe how	w injury occurr	ed		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State 31. Date Illed (Month, Day, Year)  32. Registrar's Signature	Ö	atio	2 ☐ Accident investigation	n	, , , , ,				ło					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State 31. Date Illed (Month, Day, Year)  32. Registrar's Signature	N N	er de recto by ti	determined	286. Place of Injur	y - At home, fam (Specify)	, street, factor	y, office		28f. Loc City	ation (Str.	eet and Numb Stete)	er or Rura	Route Number,	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State 31. Date Illed (Month, Day, Year)  32. Registrar's Signature		C of in			(-)//								26.0	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State 31. Date Illed (Month, Day, Year)  32. Registrar's Signature		Hosp 4 hou Fune lety fil	(Check only 2   Medical Exar	niner: On the basis of e	xamination and/	eath occurred	at the t	ime, date end opinion, death	place, and due	to the care time, de	use(s) and ma	nner as st	ated. the cause(s)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State 31. Date Illed (Month, Day, Year)  32. Registrar's Signature		Wed The	one)	and manner state	ed.									
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State 31. Dale Illed (Month, Day, Year) 32. Registrar's Signature		(0)	30. Name and address of persen who	completed cause of dec	ath (Item 23a) (T	pe, Print)		1.	1.1	0.	)   /.	0.1		
State		State		32. Registrar	's Signature	الل وا	140	- bole	, []	1	419			
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# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

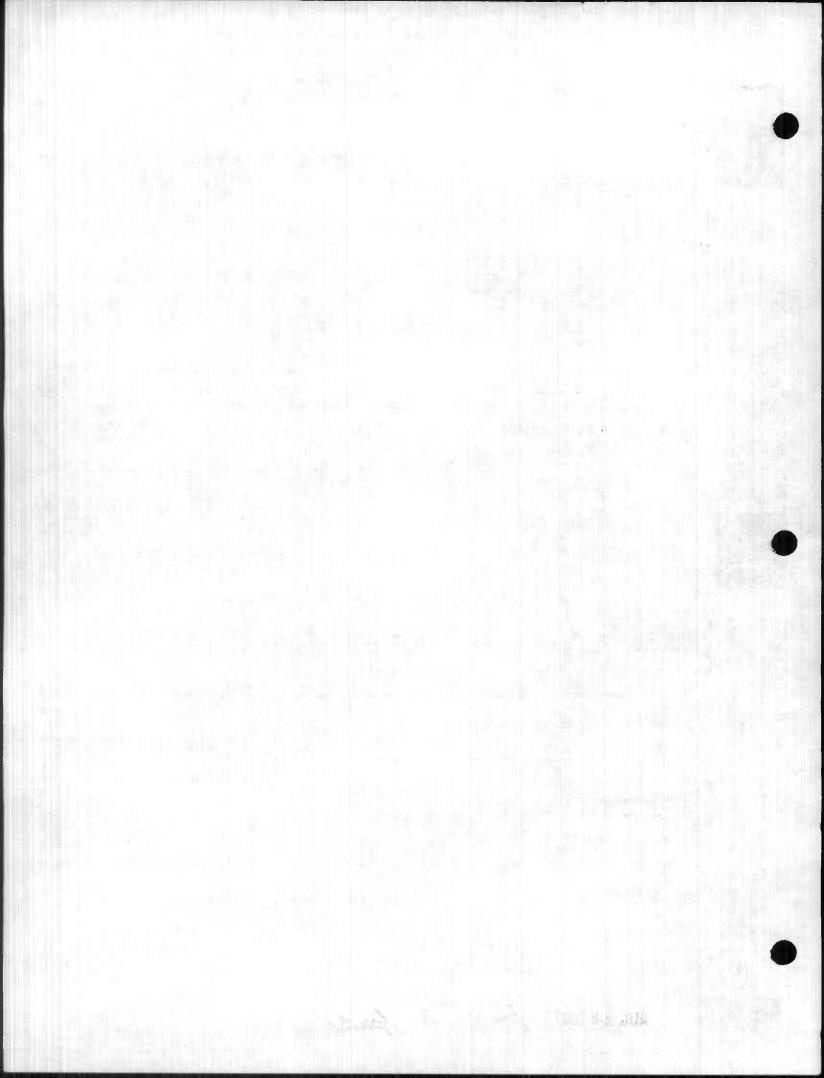
100		Amended #20b,08/		пс Се	rtificate of	Death	2. Date of Dee	Reg. No.	3	Time of Death
Phys	ician			RIJSWIJ	ICK		Month	Day	Year	0440
	dical niner	4a Facility Neme (II not institution, gh PENINSULA REGIONA	re street end number)		CK	4b. City, Town, or Lo		4c. County	of Death COMICO	0440
Funer Direct		5. Sociel Security Number 6. 5 518-90-2950	Sex 7. Age (In yrs	: last birthday, Yrs.	If Under 1 Yee Months Deys		8. Defe of Birth (Month, Day December)	Year) 22,1913	9. Birthplace Country) Shrila	(State or Foreign
2		Usual Residence of Decedent	, , , , , , , , , , , , , , , , , , , ,						1.2.4	
Marylar ef show fled at	ector	Maryland Wicomi		Salisbu						nside City Limits  Yes 2 XNo
th with the M 23a or 28a-f ast be notifie	al Direc	10e. Street end Number 160 Morris Mill	Rd.	71	10f. Zip Code 21.80	4		10g. Citizen of V Netherl		
020 un after dea af, or flams Examiner in	by Fune	11. Meritei Stetus  1 Never Merried 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates:	U,S. 13.	Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 XNo	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rac Biad Specify	e - American frok, White, etc.	
2950 21215-0020 4 within 72 hours at pers. Then "netural, or the Medical Exam	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ducetion ade completed) College (1-4or 5+)	(Give	dent's Usuai Occu kind of work done DO NOT use retin	ipation a during most of work ad)	ing		usiness/Industr	у
		17. Father's Name (First, Middle, Last	)	HOI	ellaver	18. Mother's Name	(First, Middle,		stic	
Vian	To Be	Wallace Ander	son			Const	ance	DeHoedt		
Mar Mar Mar Mar Mar Mar Mar Mar Mar Mar		19a. Informant's Name/Relationship ( Shirley A. Morri				et end Number or Run Mill Rd.,				(0)
altimore, mil. Pages 1 a portant. If Item y Injury or othe		20a. Method of Disposition  1 2 Burial 2 Cremation 3 5 4 Donation 5 Other (Speci	Removel from Stete	cemetery, cre	osition (Neme of metory or other pl	Cemetery +8	87 <del>2</del> 9/20		City or Town,	
Baltir permit. P Department Importan any Injur	9500	21. Signature of Funeral Service Lice		P F	2. Name and Adda Holloway	ress of Facility Funeral Ho	ome Proi	fessiona	al Asso	
		23a. Part1. Enter the disease, or com shock, or heart feilure. List only	polications that caused the des	ath Do not en	01 Snow	Hill Rd.,	Salisbu	iry, MD		oroximete
Box 68760, Sent of the sent of the sent certificate be executed at a strending physician and dior use as the bunal-transit	ledical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	for as a conse	quence of):	ailme				
Box Box auth cent for use	lan									
P.O. Bo that the death od by the atten detached for u	Physic	Part II. Other significant conditions	contributing to death but not re		W C Link	1	23b. Dfd t		ntribute to the	cause of death y 4 Unknow
cords, v requires been sign should be	Completed by Physician/M	7000000			00-1-4-4-4		24e. Was perlo	en autopsy med?	availab	autopsy findings ale prior to ation of cause
Re he la se he se	dwo						101	res 2 No		s 2 No
Vital Re- ician: The lav certificate has rector, page 2	BeC	25. Was case referred to medical				26. Place of Deat		. ,		
Of Vita Physician: r this certific	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 20	ER/Outpatie	nt 3X DOA	ther:	me 5 Resid		ner (Specify)	
Afte fune		27. Menner of Death  1 Natural 5 Pending 2 Accident investigation	26e. Dete of Injury (Month, Dey Year)	26b. Time of Injury	W	ury at ork?  Yes 2 No	26d. Describe h	now injury occur	red	
Division or Attendi	Certification:	3 Suicide 6 Could not be determined		home, ferm, st	reet, fectory, office	9	28f. Location (S City or Tox		ber or Rural Ro	ute Number,
Divising To the Hospital or Attenwithin 24 hours after death within 124 hours after death or ompletely filled in by the	edical (	29a. Certifier (Check only one) Certifying Pl	nysician: To the best of my kn niner: On the basis of examin and menner stated.	nowledge, deel netion end/or in	th occurred at the overtigation, in my	time, date and place, opinion, death occurr	and due to the ded et the time,	cause(s) end mo dete and place,	anner as stated and due to the	i. cause(s)
	×	29b. Signature and title of certifier	Wennich M.	D-	29c. Licer	15384		29d. Date signe	2 00	Year)
2 310		30. Name and address of person who RODNEY A.	completed cause of death (Ite	em 23a) (Type	Print) POVVER	ST. S.	ALISBU	RY M	10 21	804
	State	31. Date filed (Month, Pay, Xear) 3	2000 32. Registrens Sign	patyre	9. la	2. 11				



	st)	2000 -	rtificate o		2. Dete of De		W-	3. Time of Death
FRANCES WHITIN	IG				August	25	2000	15:15 PM
4a Fecility Neme (If not institution, give	e street and number)	Time		4b. City, Town, or	Location of Deet	h 4c. County	of Death	
Prince George's			Whates & Vo	Chever1	у		e Geo:	0
5. Social Security Number 6. S 578-28-1181	ax 7. Aga (In	93 Yrs.	Months Day		. (Month, De			ca (State or Foreig
Usual Rasidanca of Decedant		93			July 1	0,1907	wasni	ngton,D.
10a. Stata 10b. County		c. City, Town or I	Location				100	d. Inside City Limits
Maryland Prince G	eorge's	Largo						1 1 Yas 2 □ No
10e. Street and Number 11118 Lenox Driv	Α.		10f. Zip Cod			U.S.A		<b>y</b> 7
11 Maritei Status	12. Was Dacedant Evan	rin U.S. 13		of Hispanic Origin? (5	Specify Yes or No		e - America	n Indien,
1 ☐ Navar Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 21 No If Yas, Giva Year or Datas:		If Yas, specify C	uben, Mexican, Puar	to Rican, atc.)	Blad	ck, White, at v: Blac	
15. Decedent's Ec	ducetion de completed)	16a. Dec	edent's Usuai Oc	cupation	ndkina	16b. Kind of B	usinass/Indu	ustry
Elementary/Secondary (0-12)	Collega (1-4or 5+)			na during most of wo				
12th 17. Fathar's Nama (First, Middla, Last)		Nu	rse's As		ma (First, Middle	Gover		
Unknown				Rose	Taylor	, maidan daman	/	
19a. Informant's Name/Ralationship (	Type, Print)	19b. Ma	lling Addrass (Str	eet and Number or R		er, City or Town,	State, Zip C	Coda)
Serilda D. Godfr	ey/Cousin	1111	8 Lenox	Drive, La	rgo, Mar	yland 2	0774	
20a. Method of Disposition  1 ABuriai - 2 Doremation 3	Demovel from State	camatary, cr	position (Nama of amatory or other	placa)	08 Data 30	20c. Location -		m, State
4 Donation 5 Other (Specific	y) =	Riverdal Harmony	e Park (	Park	2000			aryland
21. Signature of Funeral Service Licar	isea .	larmony	22. Nama end Ad J. B. JEN	Park dress of Facility KINS FUNER	RAL HOME			
23a. Part1. Enter the disease, or com shock, or heart to the List only	Vercentre		7474 Lane	dover Road	Lando	ver, Man	yland	20785
rasulting In death)	a. CO/O/VC	a to (or as a cons	equence of):	disa	50			
Sequentially list conditions, if ery, laading to immediate causa. Enter Underlying Causa (Disaasa or Injury that initiated avants resulting in death) Last	Due c.	a to (or as a cons o to (or as a cons o to (or as a cons	equence of):	H Fa	iluse			
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					State of Ivia	iyiaiiu			of Death	werkar rry	Reg. No.	2	9181
	Physician		- marketing	(First, Middle, Last)	WEE	EM	5			2. Date of De Month Augu	Day	Year 2000	3. Time of Death
	/Medical Examiner		acility Neme (#	not institution, give	street and number)	TA	/ -		4b. City, Town, or RANDAL	Location of Deat	h 4c. County	of Death	MORE
	Funeral Director	5. So	ocial Security No	8201 6. Sex		(In yrs. las	st birthday)	If Under 1 Ye Wonths De		(Month, De	th by, Year)	9. Birthpl Count	ace (State or Foreign ry) LTIMORE, MI
1	No. 10		State	10b. County		10c. City,	Town or Local	tion				10	Od. Inside City Limits
-	18a-1 st collified ector		MD			BA	LTIMO	RE					¹X Yes 2□No
-	or 28a-	106.	Street and Nun					10f. Zip Cod			10g. Citizen of W	hat Couni	ry?
	oral prair			CLIFTON	AVENUE  12. Wes Decedent E	vor in II C	12 We		216 of Hispanic Origin? (5	Presity Ves or No	U.S.	A.	n Indian
020	if, or items traminer m		Meritel Stetus  Never Merrid  Widowed	ed 2 Married	Armed Forces?  1 Yes 27 No If Yes, Give Yeer or Detes:		If Y	es, specify C	uban, Mexican, Puer	to Rican, etc.)		k, White, e	
21215-0020			/Cnac	15. Decedent's Educ			16a. Deceder	nt's Usual Oc	cupation ne during most of wo	rkina	16b. Kind of Bu	siness/Ind	ustry
121	ygiene.  set than "natura".  4. the Medical.	EI	ementary/Secon	fy only highest grade ndery (0-12)	College (1-4or 5+	-)	life. DO	NOT use re	hired)	rking			
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ore,	Mam other	20a.	Method of Disp	osition		20b. Pled	ce of Disposit	ion (Neme of		Date 8-	20c. Location -		
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	hysician /Medical Examiner	Imm	nediate Ceuse (lase or condition liting in death)	Final /	SEVER	REI		e I C	etying, such es cardia			7	Approximete Interval Between Onset end Deeth
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. 5	ed for	Pert	II. Other algnifi	cant conditions con	tributing to death but	not resulti	ing in the und	erlying cause	given in Pert I.	23b. Dtd	tobacco usa cor	tribute to	the cause of death?
s, P.O	been signed by the ettending about be detached for use about by Physician/W		DM,	CABG						10	Yaa 2 No	3 ☐ Prot	unknown
Records,	8 0 0									· 24a. Was	en eutopsy ormed?	ava	re autopsy findings hilable prior to appletion of cause death?
	ate has page 2									10	Yes 21 No	10	Yes ZINO
of Vital	s certificate director, pag		Wes case referr						26. Plece of De	eth (Check only	one)		
of Vita	00		Yes 2	NO	lospitel: 1 Inpatien		R/Outpatient	3LI DOA		T	idence 6 Othe		)
O UC	Affect funeral lon:	27. 1	Manner of Deeth	5 Pending	28e. Dete of Injury (Month, Dey	Year) 2	8b. Time of Injury		njury at Work?	28d. Describe	how injury occurr	ed	
Division	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Accident Control Contr	Investigation 6 Could not be determined	28e. Pleca of Injurbuilding, etc.	ry - At hom (Specify)	e, term, stree		Yes 2 No		(Street end Numb wn, State)	er or Rura	Route Number,
To the Hospital	in 24 hours he Funeral pletely filled edical C	296.	Certifier (Check only one)			xaminetio			e time, dete end plec by opinion, death occ				
- 2	within To the compl		Signature and	title of certifier	- 1			29c. Lic	ense number		29d. Dete signed		
			•	6.1	hu ki	1		D	3733	3	AUGUST	24	, 2000
	6	30. 1	Neme end addre	ess of person who co	mpleted cause of de	eth (Item 2 NHZ	(3e) (Type, Pri	FLT,	MORE +	102	1133		
	State Registrar	31. [	Dete filed (Mont	n, Day, Year) 2, 8, 2000	32. Registre			1.					



Baltimore, Maryland 21215-0020

#### Please Type or Print In Black Indelible Ink Assure All Copies Are Legible

10d. inside City Limits  1⊠ Yes 2□No  10g. Citizen of What Country?  U.S.A.  14. Race - American Indian, Bleck, White, etc.  Specify: Black  16b. Kind of Business/Industry  Private  Meiden Sumeme)  Ser, City or Town, State, Zip Code)  Maryland 20770  20c. Location - City or Town, State  Landover, Maryland  ver, Maryland 20785
h 4c. County of Deeth  Prince George's  th 9. Birthplace (Stete or Foreign Country)  21,1970 North Carolina  10d. inside City Limits 1
9. Birthplace (Stete or Foreign Country) 21,1970 North Carolina  10d. inside City Limits 1 × Yes 2 No  10g. Citizen of What Country? U.S.A.  14. Race - American Indian, Bleck, White, etc. Specify: Black  16b. Kind of Business/Industry Private  1. Meiden Sumeme)  1. Stete, Zip Code) Maryland 20770  20c. Location - City or Town, State Landover, Maryland  Ver, Maryland 20785
21,1970 North Carolina    10d. inside City Limits   1\overline Yes 2 \overline No     10g. Citizen of What Country?     U.S.A.     14. Race - American Indian, Bleck, White, etc.     Specify: Black     16b. Kind of Business/Industry     Private     Meiden Sumeme)     Ser, City or Town, State, Zip Code)     Maryland 20770     20c. Location - City or Town, State     Landover, Maryland 20785
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uries
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ormed? available prior to completion of cause of death?
Yes 2□ No 1 1 2 Yes 2□ No
one)
idence 8 Mother (Specify) at scene
how injury occurred to tocyte  Street and Number or Flural Roule Number, wrv. State)
1

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Medical Ce State Registrar

29b. Signature end title

29c. License number

29d. Date signed (Month, Dey, Year)

O.C.M.E.

August 25, 2000

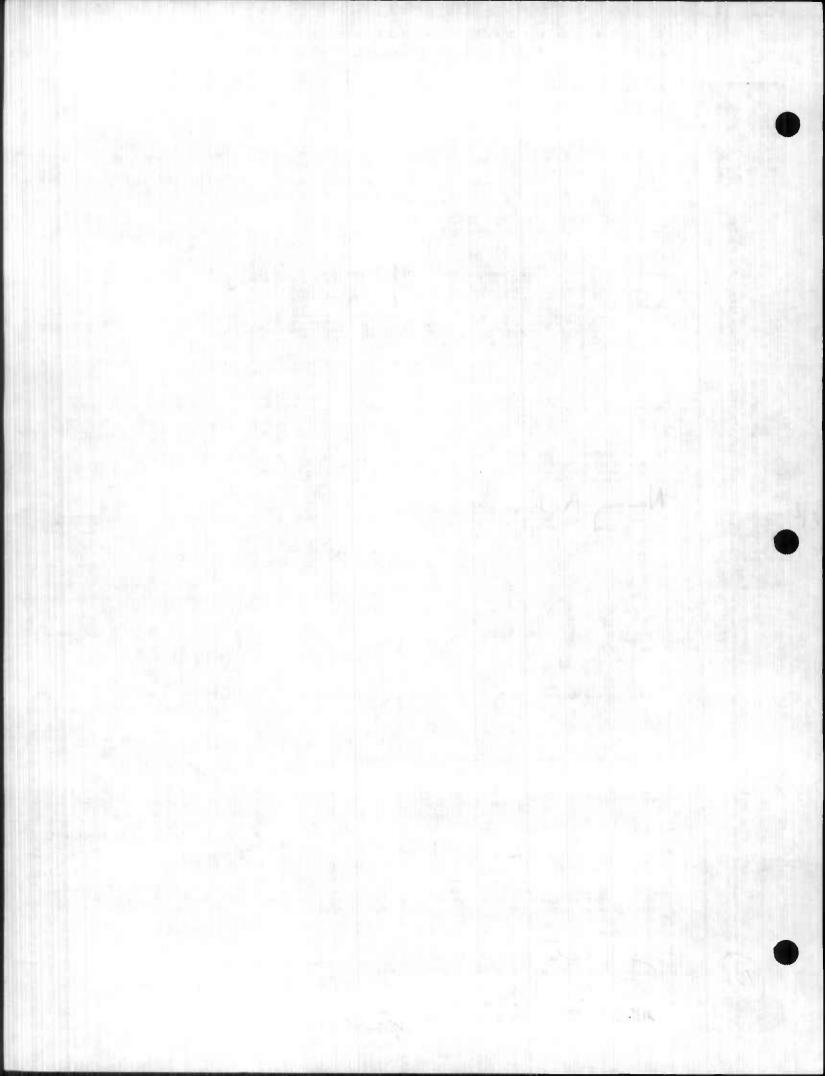
dross of person who completed cause of deeth (Item 23a) (Type, Print)

Joseph Pestaner 111 Per 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Dey, Year)

AUG 2 8 2000

22. Registrer's Signature fonds



State of Maryland / Department of Health and Mental Hygiene

			Ce	rtificate	of Death		R	leg. No.		
	1. Decedent's Nama (First, Middle, La	st)				2	Date of Dea Month	th Day	Year	3. Tima of Death
Physician /Medical	Reginald	C. Woodard,	Jr.				August			3:25 A.M.
Examiner	4a Facility Name (If not institution, gir	re street end number)			4b. City, To	own, or Local	tion of Death	4c, County	of Death	
	Prince George	's Hospital	Center		Che	verly		Prince	e Geo	rge's
Funeral Director	579-08-4026	Sex 7. Age (In	yrs. lest birthday, 21 Yrs.	Months D	ear If Under ays Hours	24 Hrs. 8 Min. F€	Date of Birth (Month, Day	1979	9. Birthp Coun Mary	lece (State or Foreign try) Land
with the Maryland a or 28a-1 show Libs notified at Director	Usual Residence of Decedent  10a. Stete 10b. County	10	c. City, Town or L Washing	ocation gton, D	.c.				1	0d. Inside City Limits 11 Yes 2 □ No
or 28a-f s be notified Director	10e. Street and Number			10f. Zip Co				10g. Citizen of V	Affroi Cour	to 2
£ 23 H W	1005 -45th Stree			20	019		1	United :	State	S
ers ath	11, Marifal Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:	in U,S. 13.		of Hispenic Ori Cuban, Mexicar No Specify:		ly Yes or No- can, etc.)		e - Americ ck, White, Bla	
ed within 72 ho ygiene. wr then "netur it, the Medical Completed	15. Decedent's E (Specify only highest gra Elementery/Secondery (0-12)	ducation ade completed) College (1-4or 5+)	(Give	DO NOT use n	lone during mos etired)	st of working	X and	16b. Kind of Bu		dustry
	12		Sale	es Cler		oda Nama //	First Middle	Maidan Cumam		
d De fi	17. Father's Neme (First, Middle, Last Reginald C. Wood					ers Name (/ rie Mo		Maiden Sumen	10)	
Manual Ma	19a. Informant's Name/Relationship		19b. Mail	ing Address (S	treet and Number	er or Rural F	Route Numbe	r. City or Town.	Stete. Zio	Code)
and 2; m 27 is her tree	Reginald C. Wood				Park D		aurel.		0724	
Hear Hear Other	20e. Method of Disposition		Ob. Piece of Disp	osition (Neme	of		Dete	20c. Location -		own, State
Page With y	1 ⊠ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		Ft.Linc	oln Cem		8/	29/00	Brentwo	od. N	1d.
anting Sortan	21. Signature of Funerel Service Lice		ity							
48E 88	1 V. 4 0 A	neer Min	s-	Alexand	er S. P	Pope F	uneral	Homes	1/ 1	20747
Physician /Medical Examiner	23a. Pari1. Enter the disease, of com shock, or heart feiture. List only Immediete Cause (Finel disease or condition resulting in death)	one cause on each line.	LTIPLA to (or as a conse	E GVN				rest,	1 1 1 1	Approximate Interval Between Onset and Death
nding physician and use as the burks: transit use as the burks: transit in/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last	c	to (or as a conse							
for ath	Part II. Other significant conditions of	contributing to death but no	of resulting in the	underlying caus	e given in Part I	1	23h Did t	obacco use co	ntribute to	the cause of death?
hat the od by the detach	- String and the stri	ormoding to double but he	i resulting in the	and onlying dads	o given in r arr		1 🗆 1			bably 4 Unknow
The law requires page has been sign page 2 ahould be Completed by						<u></u>	24e. Wes a	an autopsy med?	av	ere autopsy findings allable prior to impletion of cause death?
Physician: The law requires this certificate has been signeral director, page 2 should be raid of the Completed by							1)OY	'es 2□No	1	CYes 2 No
entific ector Be	25. Was case referred to medical axaminer?	Hospital:				e of Death (	Check only o	ne)		
His His	1 XYes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie					lence 6 Oth		(y)
After fune	27. Menner of Death  1 Naturel 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	4 6 51 00	ar) 28b. Time (Injury) 225	- 101	Injury et Work? 1 Yes 2	(No	SUB:	SECT C	NAS.	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune Medical Certification	3 ☐ Suicide 6 ☐ Could not be determined		At home, farm, si pecify)	reet, factory, of	fice	28	r. Location (S City or Tow	orreet and Number, Stete) 80	103 (	RANDAUM.
To the Hospital within 24 hours a To the Funeral Completely filled		nysician: To the best of my niner: On the besis of exa and manner stated.								
To with To to com	29b. Signeture end title of certifier				cense number			29d. Date signe	d (Month,	Dey, Year)
0	1 //	- N.11	0,	C	C.M.E.			August	24,	2000
(6)		completed cades of death			street,	Balti	more,	Marylan	d 212	201

DHMH 16 Rev 6/95

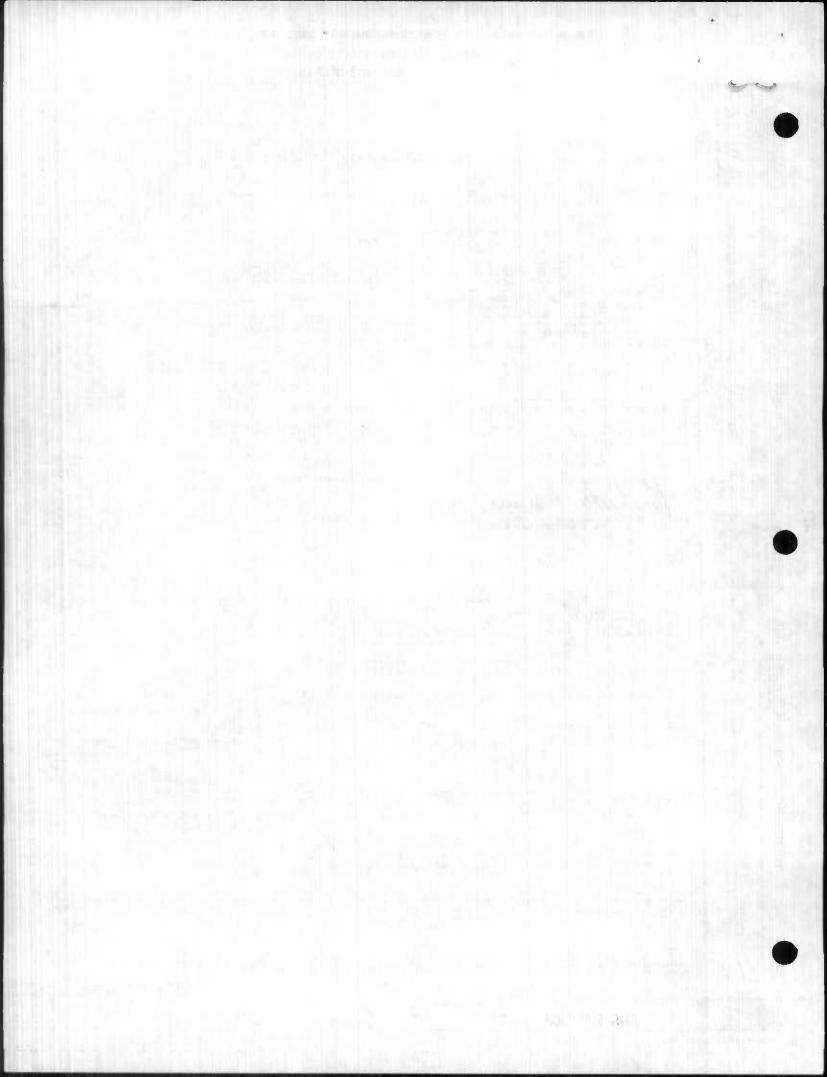
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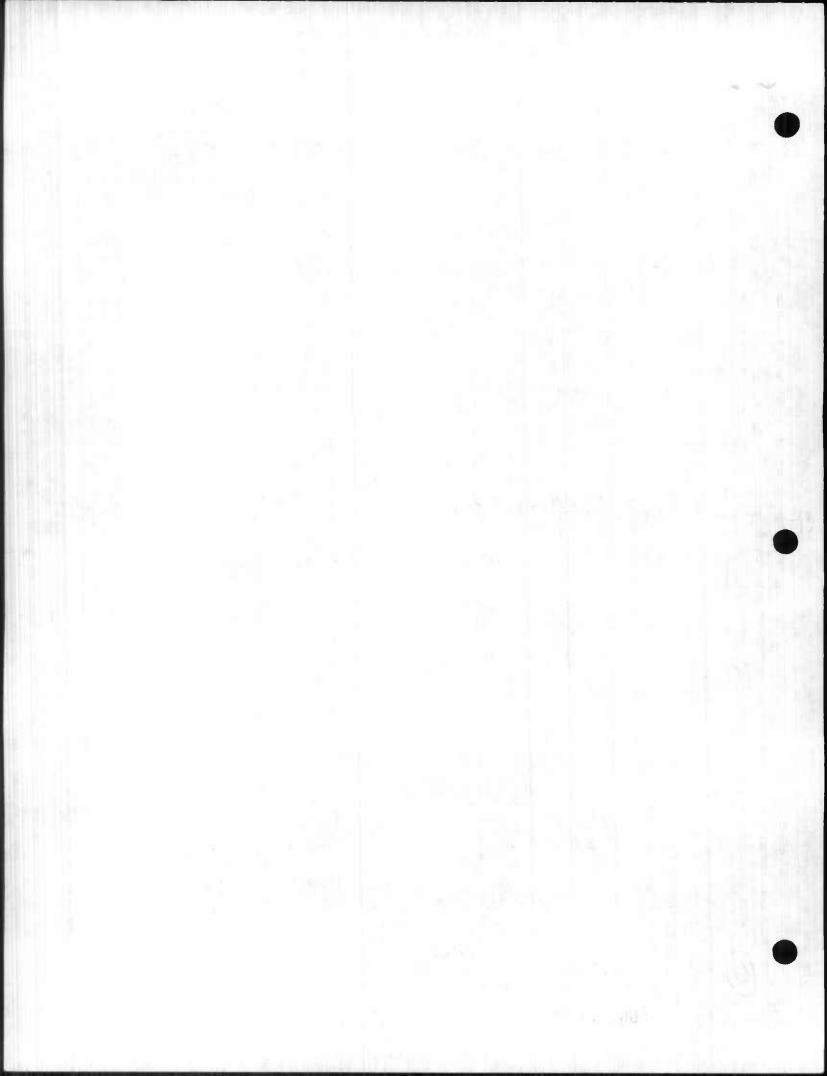
State of Maryland / Department of Health and Mental Hygiene

				Cei	tificate of	Death		Reg. No.	t-as	. 5 1 0 7				
		1. Decedent's Name (First, Middle, Li	nst)				2. Date of De			3. Time of Death				
	Physician	MAGGIE WILLIAMS					AUGUST	23, 200	Year	8:58am				
	/Medical	4e Facility Name (If not institution, gir			F	4b. City, Town,	or Location of Deal	1						
4	Examiner	WASHINGTON ADVI				TAKOMA	PARK	MONTG	OMERY					
-			Sex 7. Age (In yrs.		If Under 1 Year		rs. R Dale of Ri	rth		ce (State or Foreign				
н	Funeral Director		1□M 2DXF 83	Yrs.	Months Days	Hours M	Nov. 1	ay, Year)	Country	Carolina				
	9	Usual Residence of Decedent	1.0.0											
	ath with the Maryla 23s or 28a-f show ust be notified at ral Director	MD. 10b. County Prince (		ty, Town or Lo Riverda	_				100	1. Inside City Limits 1 ☑ Yes 2 ☐ No				
	or 28a-f s be notified Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country	y?				
	al D	6011 Mustang Driv	<i>r</i> e		20732			United	State	es				
	far death r hams 23 liner must Funeral	11. Marital Status	12. Was Decedent Ever in U	J,S. 13. \	Wes Decedent of H	lispanic Origin?	(Specify Yes or No erto Rican, etc.)	o- 14. Rac	e - Americar					
Maryland 21215-0020	by by	1 Never Merried 2 Merried 3 M Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		TYes, specify Cuba	Specify:	eno rican, etc.)	Specify	ck, White, at y: B]	Lack				
20	72 ho	15. Decedent's E		18a. Deced	ient's Usual Occup	pation	unding	16b. Kind of B	usiness/Indu	stry				
27		(Specify only highest gr Elamantary/Secondary (0-12)	Collega (1-4or 5+)	life. I	kind of work done DO NOT use retired	d)	working							
21	led within typiens. ner than it, the Me	9th grade	00110ga (1 401 04)	Domes	stic			Privat	e					
P	Be C	17. Father's Name (First, Middle, Las	)			18. Mother's I	Name (First, Middle	e, Maiden Sumen	ne)					
lar	o feed o	Willie Benjamin				Lizzy	Edwards							
ary.	N De N	19a. Informant's Name/Relationship	(Type, Print)	19b. Mallin	ng Addrass (Street	and Number or	Rural Route Numb	ber, City or Town,	, Stete, Zip C	Code)				
ž	D d d d d d d d d d d d d d d d d d d d	Cynthia Williams		6011	Mustana	Drive	Riverdal	MD 20	737					
ē,	T 940	20a. Mathod of Disposition	20b.	Place of Dispo	sition (Neme of		Date	20c. Location		n, State				
more	0 = 0	1 N Burial 2 □ Cremation 3 [	JRemoval from State		netory or other please.		8/30/88	Bronts	nood N	Maryland				
=	4 6 6	4 Donation 5 Other (Special Signature of Funeral Service Lice	**		. Name and Addre		1			eral Home				
Ba	Depa Impo any is any a	21. Signature of Funeral Service Lice	The same				W WDC 20		is run	order frome				
		23a. Part1. Enter the disease, or con shock, or heart tailure. List only	nplications that caused the dear	th. Do not ent	ar tha moda of dyir	ng, such as card	diac or respiratory	arrast,	1 1	Approximate				
	Physician Physician	shock, or heart tailure. List only								nterval Between Onset end Death				
	/Medical	Immediate Cause (Final	C AD NO	Quita	LORGIEM	ARI	PERT							
	Examiner	Immediate Cause (Final disease or condition resulting in death)  a. CARDO FULL PARTY ARREST  Due to (or as a consequence of):												
н			Dua to (	or as a consac	juence of):				i					
	nin nsit		b. SEPTICO											
	physician and sthe burishtransit	Sequentially list conditions, if any, leading to immediate		or as a conseq	juence of):									
09	be e dician buris	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	· PNEUM	Wreliff					İ					
68760,	ficate be physicials the burner t	Thet initieted events resulting in death) Last		or as e conseq	uence of):	0			1					
9 X	N B B B		6 GEDSTA	ge k	EVEAL	Des	EASE							
Вох	the str													
0	uires that the death ce signed by the attendi Id be detached for us, d by Physician/	Part II. Other eignificant conditions	contributing to death but not ras	sulting In tha u	ndarlying cause giv	ven in Part I.	23b. Did	tobacco uae co	ontribute to 1	the cause of death?				
9	that the ned by detac						1□	Yes 2⊠ No	3 Probe	ibly 4 Unknown				
of Vital Records,	signe be d								Took Was	a contrata disalisa				
ord	The law requires tate has been sign page 2 should be Completed by						24a. Wa: perl	s an autopsy formed?	avai	e autopsy tindings labla prior to pletion of cause				
ec	has b									aath?				
E .	The is page page	DATE OF THE					1 🗆	Yas 2 1 No	10	Yes 2 No				
ita	certificate rector, page	25. Was case referred to medical				26. Place of	Death (Check only	one)						
>		examiner? 1 Yes 2 No	Hospital:	ER/Outpatier	t 3 DOA Oth	her: 4 Nursin	g Home 5 Res	sidence 6 🗆 Otl	her (Specify)					
	a Physical derail d	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injui	ry el	28d, Describe	how injury occu	rred					
10	oding inth.	1 Natural 5 Panding 2 Accident Investigation		Injury		Yes 2 No								
IS	Attending or death. ector: After by the fune tiffication	3 Suicide 6 Could not t	Zoa. Place of injury - At h	ioma, farm, str	eet, factory, office			(Street end Num	ber or Rurel	Route Number,				
Division	24.75	4 Homicida	building, etc. (Speci	fy)			City or To	own, State)						
	Hospital 24 hours Funeral stely filled Jical C	29a. Certifier 154 Certifying Pl	hysician: To the best of my kno	owiedne death	occurred at the tir	ma data and ni	ace and due to the	a causa(s) and m	annar as sta	ited.				
	he Hospital in 24 hours he Funeral pletely filled edical Co		miner: On the basis of axamina and manner stated.											
	To the Hospital within 24 hours a To the Funeral Completely filled	29b. Signature and/little of certifier	and marrier states.		29c. Licans	sa number		29d. Date signe	ed (Month, D	lay, Year)				
	F \$ F 8	A topon to	140		NI	1509								
	1	WAY OF	MD		174	0001		749	usi.	4 0000				
	0	30. Name and addrass of person who	completed causa of death (Item 79 KIJAKA 7	m 23a) (Type,	Print) HATPING	e PAR	knay (	GRECORE	BELT	24 2000 MARILANS				
	State	31. Date filed (Month, Day, Year)	32. Begistrar's Sign	ature	1	1.41	,							
	Registrar	AUG 2 9 200	He farmer	13	doub	1								

DHMH 16 Rev 6/95



CHELLE R SLEY		State of Maryla		rtment of F		Mental I	Hygiene Reg. No.	0.0	29105				
Physician /Medical	MICHALLA RA	nee Wesley				2. Date of Month AUGUS	Day		3. Time of Death 23:20 PM				
Examiner	An English, blome (Mant Institution of	re street end number)			4b. City, Town, or L Fairmont		D	County of Death RINCE GE					
Funeral Director	377-02-4909	Sex 7. Age (In y	rs. last birthdey)35 Yrs.	If Under 1 Yeer Months Days	If Under 24 Hrs. Hours Min.	8. Date of	Birth Dey, Year)		place (State or Foreign ntry) ington, D.C.				
with the Maryland a or 28a-f show be notified at	Usual Residence of Decedent 10a. State 10b. County Maryland Prince G		City, Town or Local						10d. Inside City Limits 1 ☐Yes 2 ☐ No				
th with the Ms 23a or 28a-fr ust be notified		s Rd.		10f. Zip Code 207	46			zen of What Cou					
her day	11. Marital Status 1⊠ Never Merried 2□ Married	12. Was Decedent Ever in Armed Forces?  1  Yes 2 No If Yes, Give Year or Detes:			lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes on Rican, etc.	)	14. Rece - Ameri Black, White Specify: B1a	, etc.				
med 2 should be filed within 72 should be filed within 72 strong to 27 is metriced other than "net are traumetic event, the Medical To Be Complete	15. Decedent's E (Specify only highest gri Elementery/Secondary (0-12) 12		(Give k	O NOT use retired	during most of world			nd of Business/Ir ivate	of Business/Industry				
	17. Father's Name (First, Middle, Last)	)		other's Neme (First, Middle, Maiden Sumeme) Lavern Wesley									
	19a. tnformant's Name/Reletionship (Type. Print)  Lavern Perry / Mother  19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, 2 3815 St. Barnabas RD. #101 Temple Hills												
	20a. Method of Disposition    20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece)   Date												
Baltimore permit Pages 1- Department of He Important if Nem any Injury or oth atte.	21. Signatura of Funeral Service Licer	and Moss	-	538 Mar.	ss of Facility r S. Pope lboro Pik	e/For	estvil		20747				
Physician /Medical Examiner	23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  A ULTIPLE GUNSMOT WOUNDS  Due to (or es a consequence of):												
OX 68760, certificate be executed rightly physician and use as the burial-transit or Macrices is examined.	Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as a consequenca of):  C. — Due to (or as a consequence of):											
that the death ed by the attel detached for the physician		dcontributing to death but not resulting in the underlying cause given in Part I.							to the cause of death?				
The law requires that the has been signed to page 2 should be defined by P.				- 4			Nas an autopoerformed?	a c o	Vere autopsy findings vailable prior to ompletion of cause f death?				
= - 44 0					26. Place of Dea			□ No 1	XIYes 2 No				
H die P	1 ☐ Yes 2 ☐ No	28a. Date of Injury (Month, Pey Year 0175/00	28b. Time of Injury 2365	28c. Inju		28d. Desci	ribe how injui	Other (Special Special					
or At there in by	3 Suicide 6 Could not be determined determined		AR ON	THE STR		FOCTE	ST FAI	RMONTHI	s, mo				
To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by Medical Certification of the Completely filled in the	(Check only 22 Medical Examone)  29b. Signature and title of certifier	niner: On the basis of examend manner steted.			pinlon, death occu		me, date end		to the cause(s)				
(6)	30. Name and address of person who MARY C. A. 31. Date filed (Month, Day, Year)	completed cause of death (I	111 Pe	*	et, Baltin	more,	Maryla	and 2120	1				
State Registrar	AUG 2 9 2009		19	loo de	,								



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

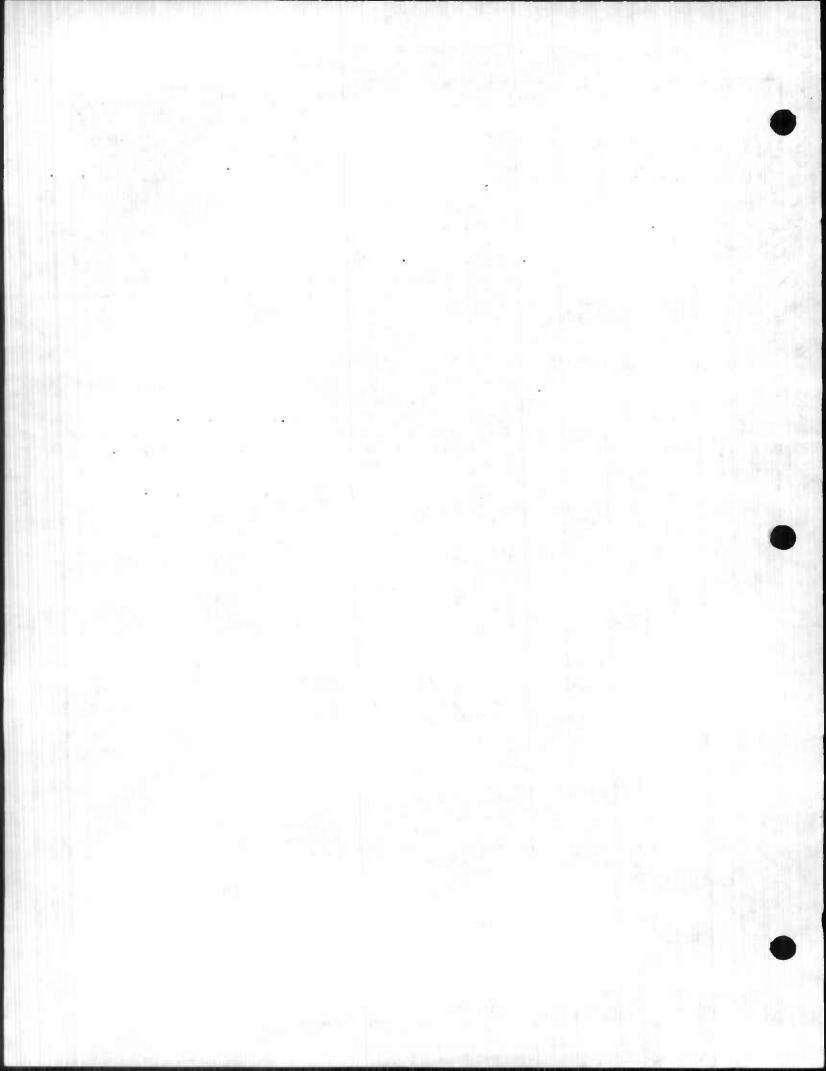
	Certificate of Death	Reg. No.
Physician /Medical	Percy Nathaniel Warren Jr.	2. Data of Death Amonth Day Gar Jaar J. Tima of Death Away 457 J. J. J. J. J. J. J. J. J. J. J. J. J. J
Examiner	Doctors Community Hospital Lanha	
Funeral Director	5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 579-58-9003 If Under 24 Hrs. Montha Days Hours Min Usual Residence of Decedent	
ahow Mass	10a. State 10b. County 10c. City, Town or Location	10d. fnside City Lin
or 28s-f sho be notified at Director	Md. Prince Georges Clinton	1 5 ≤ 2 □
		U.S.A.
ar, or he by Fu	3 ☐ Wildowed 4 ☐ Divorced Yaar or Datas: 1973	Specify Yas or No- to Rican, etc.)  14. Race - American Indian, Black, Whita, atc.  Specify: Black
o d	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  To Vest Sator	orking U.S. Governme
Mental H arked out artic ever To Be	Percy Nathaniel Warren Sr. Lec	me (First, Middle, Maiden Sumerne)  M. Ross
2 4 4	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or F	Jural Route Number, City or Town, State, Zip Code)
Theat them 2 other	20a. Method of Disposition  1 Provided a property of the provided and the	Date 20c. Location - City or Town, State
Department of Important: If I any Injury or DOCO.	21. Signature of Funeral Sarvice Licensae  22. Name and Address of Facility	ewis Funeral Home
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one hause on each line.	c or respiratory arrest,  Approximate Intervel Between
Medical Examiner	Immediate Cause (Final disease or condition resulting In death)  Due to (or as a consequence of):  Respiratory failure	lung 3 year Sezzes 2 mon
orningte by executed inding physician and use as the burial-transit in/Medical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):	J
the attending the documents as a second of the second of t	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of de
med by the detach		1 Yes 2 No 3 Probably 4 Unk
ripsician; The law requires that the beach centricate has been signed by the attending director, page 2 should be detached for use.  To Be Completed by Physician/M		24a. Waa an autopsy performed?  24b. Were autopsy findii available prior to completion of causi of death?
certificate has rector, page 2		1 Yes 2 No
certifficactor irrector		eath (Check only one)
ding Physith.  After this funeral di	1 Yes 2 No	Home 5 Rasidance 6 Other (Specify)  28d. Describe how injury occurred
To the troopus or Attending Physician: The is within 24 hours stare death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, Stele)
Funer letely fill	29a. Certifier    Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only and Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place (Check only one)	
Within Toth	NO. STATE OF THE PROPERTY OF T	29d. Date signed (Month, Dey, Year)
	(M.D. 46200	Avg. 26, 2000 Rd, Suite #4 BLADENSA
	M. SAEED KOOLAEE MD 5632 ANNAPOLIS	Rd, SUITE #4 BLADENSA
State	31. Date filed (Month, Dey, Year)  32. Registrar's Signature	101.0

State of Maryland / Department of Health and Mental Hygiene

hysician						CE	runcau	e or i	Death		1	Reg. No.			
hysician	1. Decedent'a t	Name (First, Midd	lle, Last)								2. Date of Dec				ma of Death
	т	eola B.	t/+11-	iame							Month	Day	Yee 2000		1:07 PM
/Medical		ne (If not institutio			her)			1 4	b. City. To	wn. or Lo	August cation of Death		unfy of De		1:07 PM
xaminer					Dell										
		Cross H							ilvei				itgom		
neral	5. Social Securi		6. Sex	1 2 <del>Q</del> F 7	Age (In yrs.		) If Under Months		If Under Hours	Min.	8. Date of Birt (Month, Da	h y, Year)	9. 8	Birthplece (5 Country)	State or Foreign
ector	229-802	:040	10.14	-X	47	Yrs.					Feb. 1	5, 195	53 V	irgin	ia
		Usual Residence of Decedent  10e. State 10b. County 10c. City, Town or Location													
. 1	SEC. 27.1														ide City Limit:
to to	MD	Prince	e Geor	rges	A	delphi	Ĺ							X	Yes 2□N
be notified Director	10e. Street and	Number					10f. Zip	Code			10g. Citizen of What			Country?	
	8537 Ri	ggs Road	1					20	783			I	JSA		
Funeral	11. Marital Stat			Was Deced	dent Ever in U.	S. 13.	Was Deced			gin? (Spe	cify Yes or No			merican Ind	an,
		Married 2□ Mar	rried	Armed Ford			If Yes, spec	ify Cuba	n, Mexican	, Puerto	Rican, etc.)		Black, W	hite, etc.	
by		ed 4 Divorced		If Yes, Give			1 ☐ Yes	2 (XNo	Specify:			Sp	ecify: R	lack	
N N						16a Das	adont's Heur	I Occup	ation	-		16h Kind	-	ss/Industry	
r, the Healest Earn. Completed by F	(5	15. Deceder Specify only highe	est grade c	ompleted)		(Giv	edent's Usua e kind of wo DO NOT us	rk done	during mos	t of worki	ng	TOD. KING	OI DUSING:	samoustry	
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matic ev		nnie Wil	lliams	s, Sr					Mag	ggie	Wilcox				
		's Name/Relations	ship (Type	Print)		19b. Mai	ling Address	(Street	and Numbe	er or Rura	Aoute Number	er, City or T	own, Stete	, Zip Code)	
4	Austi	n Espeut	:/Son			8537	Riggs	Roa	d Ade	1phi	, MD 20	783			
other tre	20a. Method of		-		20b. P	laca of Disp	osition (Nar	ne of			Date		tion - City	or Town, St	ate
		2 Cremation		noval from S	tate		ematory or o				10.100			2.500	
luny luny		ion 5 Other (5			на		Memor				/2/00	Lando	ver,	MD	
eny Injury o	21. Signature of	of Funeral Service	Licensee	0	~		22. Name an				uneral	Home	Tnc		
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	23a. Part1. En	iter the diseese, o	or complice	tions that ca	used the death	n. Do not e	nter the mod	e of dyin	g, such es	cardiec o	or respiratory a	rest,	, D	Appro	ximete
ician	snock, or	near failure. List	tonly one	ceuse on ea	ch line.									Onse	al Between t and Death
dical	Immediate Cau	use (Final		T A	DOD DI	Outm mi	n (Dana	212		0.00				i	
niner	disease or con resulting in dea	dition	a	LA	RGE RIO			-PAR	LETAL	OCC	IPITAL			1	
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urial T	Sequentially lis it any, leading cause. Enter L Cause (Diseas	Jnderlying		HY	PERTEN	STON								1	
privilegen and as the burlattransit edical Examir	that initiated ev	/ents	C			r as a conse	quenca of):			***				1	
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attending parties as inclan/Med			d											1	
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2 2	Part II. Other st	ignificant conditi	ons contri	butting to dea	ith but not resi	utting in the	underlying c	ause giv	en in rait i	•					
ched				SPUTU	M, ANEI	AIM					10	Y88 2L	No 3L	Probably	4 🔯 Unknor
detached for us Physician/	MRSA	INFECTIO	N IN												
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be detached		INFECTIO	)N IN					-			24a. Was	an autopsy	24	svailable	topsy findings prior to
be detached		INFECTIO	ON IN								24a. Was	an autopsy	24	svailable	prior to on of cause
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Please Type or Print In Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2 Date of Death 3. Tima of Death Month **Physician** ADDIE PURNELL WHALEY /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN If Under 1 Year If Under 24 Hrs. 8. Data of Birth
Months Days Hours Min. [Month, Day, Year] 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foraign Country) Funeral 1□M 20XF Yrs. 1905 BERLIN, Director 219-07-7548 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo MD. WORCESTER BERLIN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA ISAIAH FASSETT APT. #16 FLOWER ST. 21811 Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - Amarican Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Yaar or Dates: 1 Never Married 2 Married 1 Yes 2 No SpecifAFRO-AMERICAN by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry ng most of working Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. mt. If them 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPER DOMESTIC 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumame) ISABELLA SELBY GEORGE A. PURNELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10533 TRAPPE ROAD., BERLIN, MD. 21811 MABLE TINGLE/SISTER Baltimore. 20b. Place of Disposition (Nama of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State CALVARY UMCHURCH CEMETERY 9-1 = 8 BERLIN, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JOLLEY MEMORIAL CHAPEL 1213 JERSEY ROAD, SALISBURY, MD. 21801 har coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Due to (or as a consequence of) Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical Due to (or as a consequence of) P.O. Part II. Other eignificant conditions contributing to death but not requiping in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 21 No 1 ☐ Yes 2 ☐ No enen Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpetient 2 ☑ EFVOutpatient 3 ☐ DOA Certification: To 1 Ves 2 No Other: 4□ Nursing Home 5□ Residence 6 □ Other (Specify) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Division 5 Pending investigation 1 TYME 2 No 2 Accident Birector: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 [1] Suicide 4 Homicide 8 To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated. 29a. Certifier mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b.-Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ted cause of seath (Item 23a) (Type, Print) 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 3 1 2000 Registrar



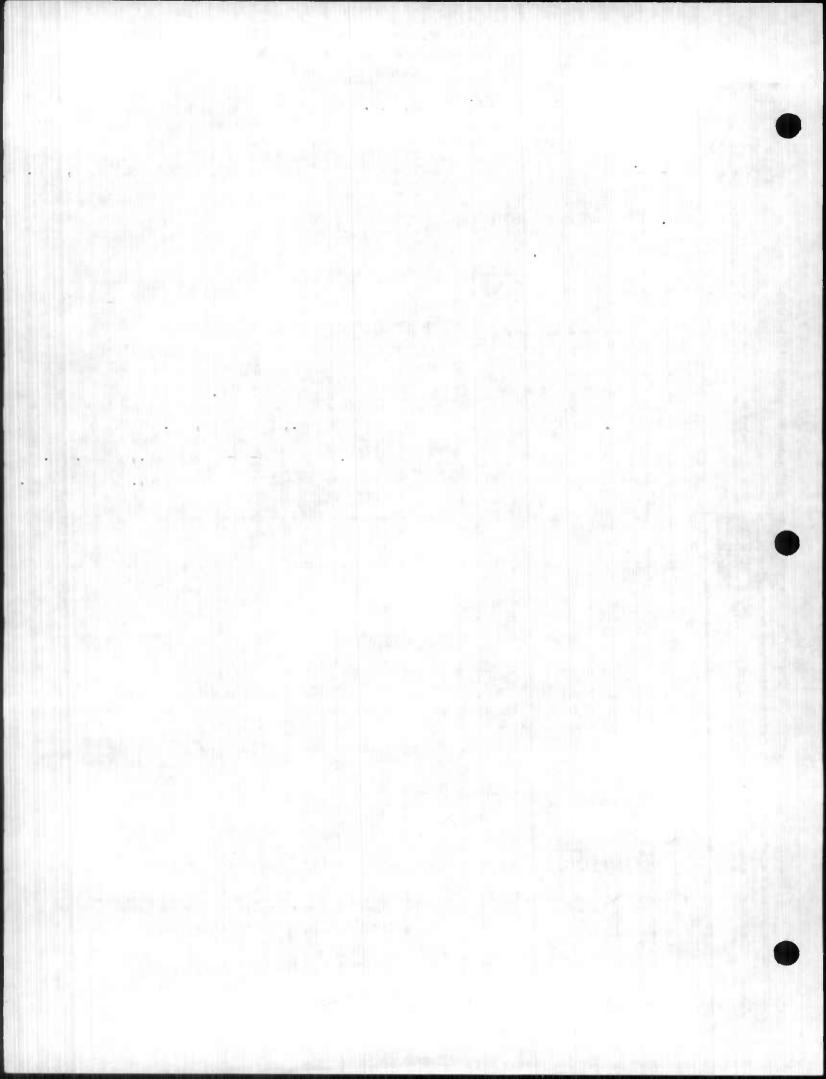
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	Physicia /Medic	_	Decedent's Name (First, Middle, Last)     WALTER	RICHA	RD W	WHITE,	SR.			2.	Date of Death Month	Day	Year 2000	3. Tima of	
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	Funeral Director		217 70 7120 1	M 2□F 7. As	ge (In yrs.	last birthday) 59 Yrs.	If Under Months	1 Year Days	If Under 2 Hours		Date of Birth	Yeq'941	9. Birthple SALTSE	CA (State of	Foreign MD •
	Maryland of show fled.st	tor	Usual Residence of Decedent  10a. Stata 10b. County  MD COUNTY	( WICO)		y, Town or Lo	cation						100	d. inside Cit	
	3a or 28a	il Director	10e. Street and Number 302 BROOKLYN AV	Ε.		13	10f. Zip	Code	2180	02	10	g. Citizen of V USA	What Country?		
5-0020	E. C.	by Funeral	11. Maritel Status  1 Never Married 20 Married  3 Widowed 4 Divorced	2. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:	?		Was Deced 1 Yes, spec	V	ispanic Orig in, Mexican Specify:	gin? (Specif , Puerto Ric	y Yes or No- an, etc.)	Blac	a - America ck, White, et AFRO-F	c.	CAN
21215-0	Jiene. Transment. The Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementery/Secondery (0-12) 1 yr	16a. Deced (Give life. L LABOR	kind of wo	rk done o	during most	of working	rking 16b. Kind of Business/Industry RETAIL/CATERER						
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imore	Pages nant of h ary or of		20a. Method of Disposition  1 Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)	emoval from State	GRE	EN ACR	ES ME	ther place	PARK		0-00 W	EST RD			ID.
Balt	Depart Depart Import any in	21. Signature of Fineral Service Licensee  22. Name and Address of Facility 1213 JERSEY RO  JOLLEY MEMORIAL CHAPEL											, . SAL		801
2	Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each life.  Immediate Cause (Final disease or condition resulting in deeth)  Due to (or as a consequence of):												nterval Beth Onset and D	ween Death
,	te be executed ysician and se burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due to (c	or as a conseq	uence of):								
x 68760,	phy phy	/Medical	Cause (Disease or Injury that initiated events resulting in death) Last		Due to (o	or as a conseq	uenca of):								
.O. Box	the death by the atternached for u	Physician/M	Pert II. Other aignificant conditions con	tributing to death b	out not res	ulting in the u	nderlying o	ause giv	en in Part i.		23b. Did tol	bacco uae co	ntributa to	the causa o	of death?
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Vitai F	icien: The la certificate he rector, page	Be Cor	25. Was case referred to medical				70		26. Piace	of Death /	1 ☐ Ye	s 20 No	10	Yes 2	No
of V	0 0	TOB	examiner?	ospital:	ient 2	ER/Outpatien	1 3□ DC	Oth Oth	or.		5 ☐ Reside		er (Specify)		
Division o	or Attending Ph after deeth. Director: After thi d in by the funeral		27. Manner of Death  1 Netural 5 Pending Investigation	28a. Dete of Inju (Month, De	ury ay Year)	28b. Time of Injury	M	8c. Injur Wor 1 □	yat k? Yes 2 □ t		d. Describe ho	w injury occur	red		
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			92%	at 14	.2.	5811	I	30	690		X	705.	26,	2000	
		1	30. Name and address of person who con Janes E. MAD	TIN M	death (Item	1 23a) (Type,	Print)	41	220+	- 4 57	., 51				
	Stat Registra	е	31. Date filed (Month Aug Year) 1 2		ei s signe	ature	y. 1	por	KN				-		

DHMH 16 Rav 6/95

Registrar

219-36-5120

Walter R. White



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Daie of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death **Physician** Frank Ira Albin SEPTEMBER 13.2000 10:37 PM /Medical 4e Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Saint Joseph Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1XM 2□ F 79 069-14-9249 Yrs Director November 10 1920 New York Usuai Residence of Decedeni 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tr than "naturel", or flams 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yas 2 ☑ No Maryland Baltimore Parkville Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd. Apt. 3110 21234 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Year or Dates: 14. Raca - American indian, Black, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married WW II 1 ☐ Yes 2 No Specify: White Specify by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) Coilege (1-4or 5+) 5+ Engineer Aerospace 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Pages 1 and 2 should be nent of Health and Mental int: If Item 27 is marked or Ira S. Albin Elizabeth E. Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code, Caroline K. Albin (Wife) 8800 Walther Blvd. Apt. 3110, Parkville, MD 21234 20a. Method of Disposition

1 Buriai 2 Ocremation 3 Removal from State 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State 6 permit. Page Department of Important: If eny injury or once. 9/15/00 Green Mount Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate intervai Between Onset and Death Physician Immediele Cause (Finel disease or condition resulting in daath) /Medical MULTISYSTEM ORGAN FAILURE SYNDROME 13 DAYS Examiner Due to (or as a consequence of): Examiner GASTROINTESTINAL HEMORRHAGE UPPER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due io (or as a consequence of) PEPTIC ULCER DISEASE Physician/Medical Due to (or es e consequenca of) 080 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yas 2 No 3 Probably 4 Unknown CORONARY ARTERY DISEASE py 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed page 1 ☐ Yes 2 No 1 Yes To the Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 inpatient 2 ☐ ER/Outpelient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To this 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 1 Natural 5 Pending investigation after deeth. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piace of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funerel C 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a Certifier completely 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 14-2000 D 30263 30. Name and address of person who completed cause of deeth (item 23a) (Type, Print) FRANCIS KHOO, M. D 7601 DS ER MARYLAND 5 2000 31. Date filed (Month) 32. Registrar's Signature State

Registrar

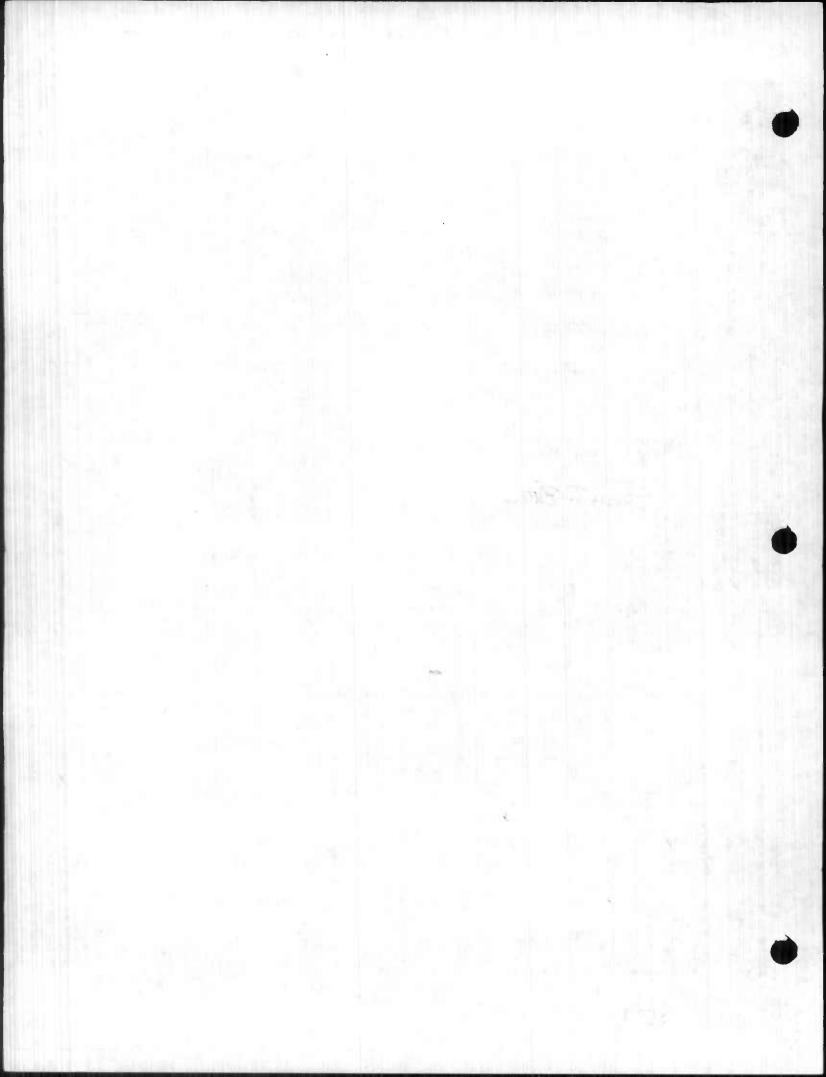
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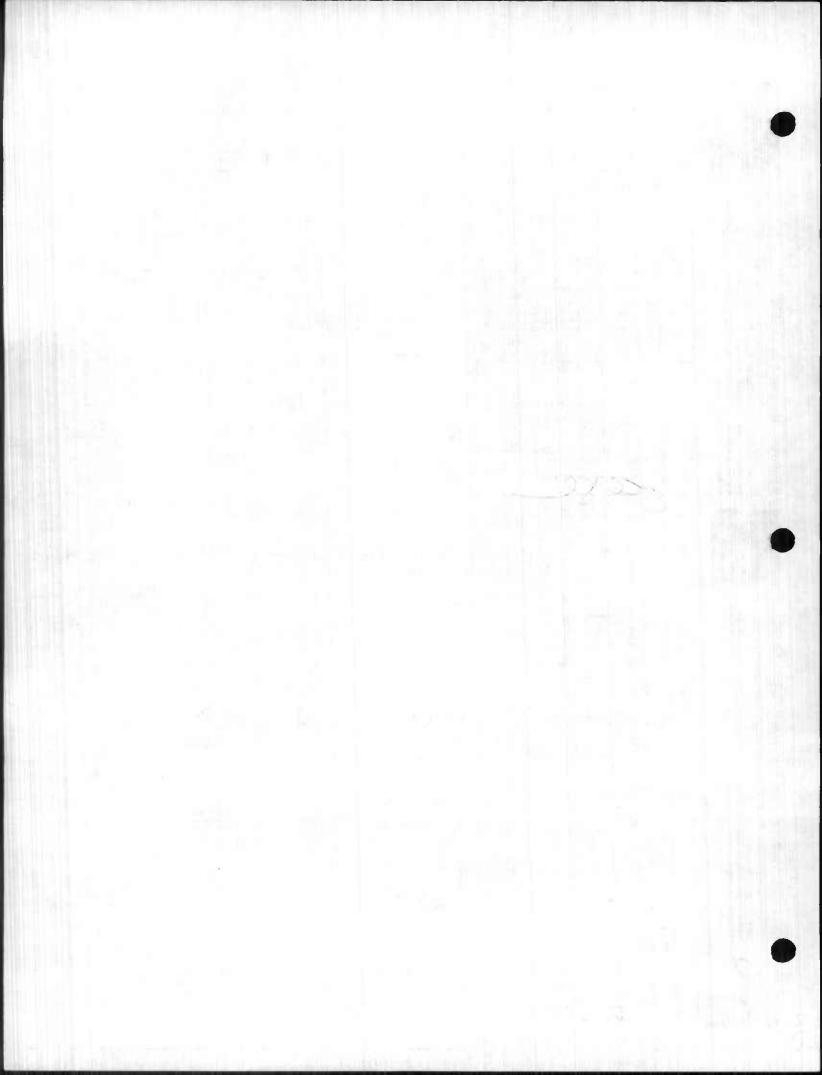
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State of Maryland / Department of Health and Mental Hygiene 00 29 | 9 |

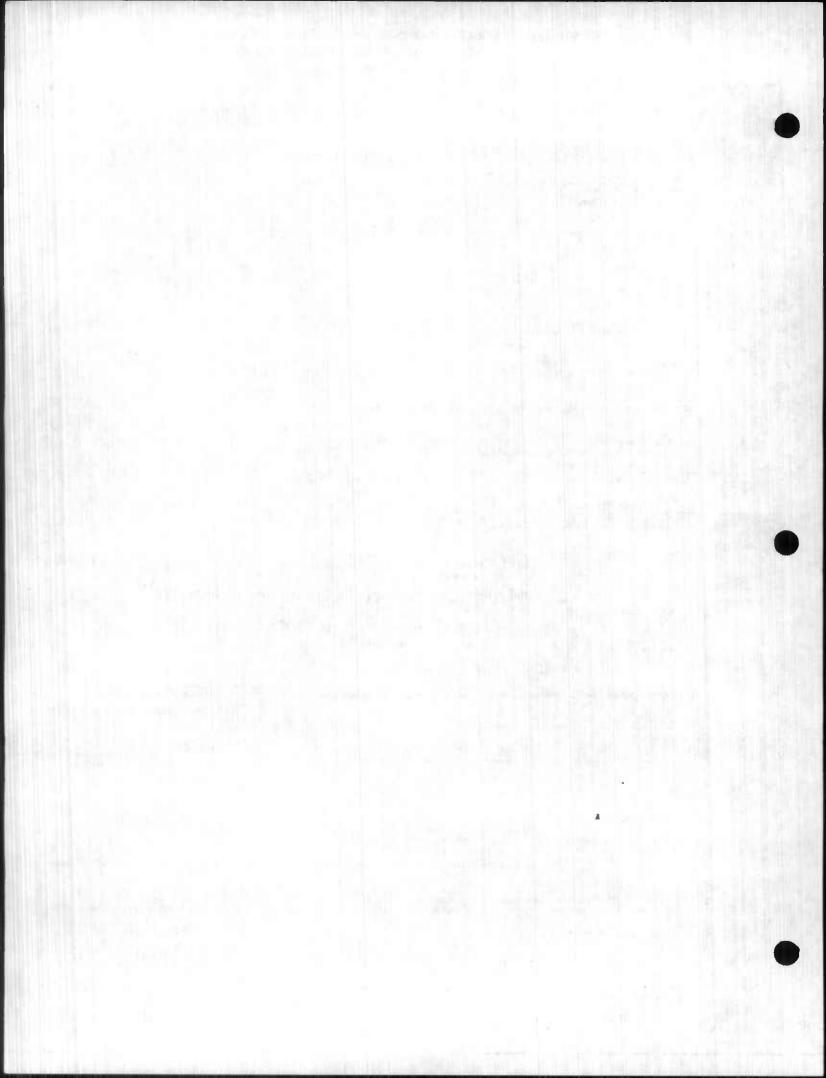
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10	Albert I. W	arter	5					Marg	guerii	te B. C	Campbe	II		
	19a. Informant's Name/Ratat										, City or Town,			
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any injury or other tr	20a. Mathod of Disposition 1 A Burial 2 ☐ Cremati	on 3 DF	Ramoval from State		Place of D cometery,	isposition (N crematory or	ame or other pla	ice)	i	Data	20c. Location -	City or To	wn, Stata	
	4 Donation 5 Otha				w Ca	athedr	al C	em.	9/	15/00	Baltimo	re, N	ID	
Suce.	21. Signatura of	25000	00					ess of Facilit	y					
a	Michael	, FIE	igle			10 W	non Pac	Funer	al Ho	me Timon	ium, M	D 210	102	
	23a. Part1. Entar tha disease shock, or heart failure.	. or comp	lications that cause	d tha dea	th. Do not	enter the m	ode of dyi	ng, such as	cardiac or	respiratory arm	est,	0 211	Approxima Interval Be	te
an cal ner	Immediata Causa (Final disaasa or condition rasulting in death)		. CHRON			VCTIVE		LMON	ARY	DISEA	ISE	1 1 1 1	Onset and	5(+)
Examiner	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	1	b	Due to (	or as a cor	nsequence o	<b>)</b> :	۳	т					B
e as the burial-transit Medical Examir	Cause (Disease or Injury that initiated evants resulting in death) Last	1	c	Dua to (d	or as a cor	nsequence of	):							
etached for use			d											
Physic	Part II. Other significant con-	ditions co	ntributing to death t	out not res	ulting in t	ne underlying	cause giv	ven in Part I		23b. Did to	obacco use co	ntribute to	the cause	of death'
by Phy	CORONARI	1 Av	पद्मिप न	DISE	ASE					72	es 2 No	3 Prot	ably 4	] Unknow
pieted	will also				4					24a. Was a perform		8VB 100	re autopsy illable prior npletion of leath?	to
Com										1 U Y	es 2 No	10	Yes 2	No
Be	25. Was casa rafarred to med	lical						26. Place	of Death (	Check only on	16)	1		
2	examinar?	1	Hospital: 1 Inpati	ent 2	ER/Outpo	atient 3 l	Ott AOC	her: 4 Nu	rsing Home	e 5 Reside	ence 6 Oth	ver (Specify	)	1-19-1
	27. Mannar of Death		28a. Date of Inju	JITY	28b. Tim	na of	28c. Inju	ry at	28		ow injury occur			
0	3 ☐ Sulcide 6 ☐ Co	astigation uld not be armined	28a. Place of In	jury - At h		M	1	Yes 2		f. Location (Si	treet and Numl	ber or Rura	l Route Nur	nber,
ficati			building, e	tc. (Speci	(y)					City or Town	n, Stata)	15,5		
Certification:	4 Homicide			of routiens	włedge, d	eath occurre	d at the ti	me, date an	d place, an	d due to the cu	auco/cl and m	anner as st	ated.	
edical Certification	29a. Certifiar Certi	fying Phys cal Exami	alcian: To the best ner: On the basis of and manner st	d axamina	ition and/o	or investigation	n, in my c	opwion, dea	th occurred	f at the time, d	ata and place,	and due to	the cause(	s)
Medical Certification	29a. Certifiar Certi	cal Exami	ner: On the basis of	d axamina	ition and/o	or investigation		se number	th occurred	f at the time, d	ata and place, 9d. Data signe		the cause(	(s)
completely filled in by the fu	29a. Certifier (Check only one)  29b. Signature and little of cer	cal Exami	ner: On the basis of and manner st	of axamina ated.	ition and/o	or investigation	9c. Licens			f at the time, d	ata and place,		the cause(	(s)
pletely fill	29a. Certifier (Check only one)  29b. Signature and lifte of certifier and lifte of certifi	tifier	ner: On the basis of and manner st	of axamina ated.	ntion and/o	2 pe, Print)	9c. Licens	se number	(	f at the time, d	ata and place,	od (Month, I	the cause(	(s)



State of Maryland / Department of Health and Mental Hygiene

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		Certificate of Death	Reg. No.
Physician	1. Decedent's Name (First, Middle, Last)		Date of Death Month Day Year  3. Time of Death
/Medical	Jack Thompson Black		eptember 14, 2000 /2:12,
Examiner	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Local	1 0 1100
	Tranklin Square HOS DITAL  5. Social Security Number 6. Sex 7. Age (in yrs. lest)	hirth(lay) If Under 1 Year   If Under 24 Hrs.   8	Determine Birth Batti More
neral ector	264-22-2549 1⊠M 2□F 75	Yrs. Months Days Hours Min.	Dete of Birth (Month, Dey, Year) Oct. 4,1924  9 Birthplaca (Stata or Fore Country) Pennsylvania
	Usual Residence of Decedent  10a. State 10b. County 10c. City, To	own or Location	10d. fnside City Lim
adail o	Maryland Baltimore	Baltimore	1 ☐ Yas 2 【】
rector	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
I Dir	2 Dunsinane Drive, Apt. F	21236	u.s.A.
Funer	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 ☒ Married If Yes, Street No If Yes, Give	13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexicen, Puerto Rice 1 ☐ Yas 2 🕅 No Specify:	fy Yes or No- can, atc.)  14. Race - American Indian, Black, White, etc.  Specify: White
D D	3 Widowed 4 Divorced Year or Dates: WW 11	12 143 254 110 Specify.	
ete	15. Decedent's Education (Specify only highest grede completed)	<ol> <li>Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)</li> </ol>	16b. Kind of Business/Industry
Compl	Elementary/Secondery (0-12) College (1-4or 5+)	Purchasing Agent	Electronics
ပိ	17. Fathar's Nama (First, Middla, Last)		First, Middle, Maiden Sumema)
To Be	Florrid A. Black	Mary C	
F		19b. Mailing Address (Street and Number or Rural F	
	Mrs. Roberta Black (wife)		t. F, Baltimore, MD 21236
	20a. Method of Disposition 20b. Place		Date 20c. Location - City or Town, State
			15/00 Baltimore, Maryland
	21. Signature of Funeral Service Licensee	22. Name and Address of Facility	
8	Buin Calabilla	Schimunek Funeral H 9705 Belair Rd., Ba	lome, Inc.
	23a. Part1. Enter the disease, or complications that ceused the death. D shock, or heart feitura. List only one cause on each line.	20 not enter the mode of dying, such as cardiec or r	espiratory errest, Approximete
an	shock, or heart feilura. List only ona cause on each line.		Interval Between Onset and Death
i	Immediate Cause (Final disease or condition CARDIAC A	POEST	ONE WEE
	resulting in death)	a consequence of):	ONE WEE
iner	- CHRONIC OBS	STRUCTIVE PULMONAR	Y DISEASE
edical Examiner	Sequenfially list conditions,  Due to (or as	a consequence of):	
三田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events:	HEART FAILURE	
op De	that initiated events resulting in death) Last Due fo (or as	a consequence of):	
-	d		
clan			1
/ Physician/N	Part II. Other significant conditions contributing to death but not resulting	g in the underlying ceuse given in Part I.	23b. Did tobacco usa contributa to the cause of der
			1 Yea 2 No 3 Probably 4 Unkn
leted by			24a. Was an autopsy performed? 24b. Were autopsy finding available prior to
jet			complation of cause of death?
Completed			1 Yes 2 No 1 Yes 2 No
Be	25. Wes case referred to medicel	26. Place of Death (	
ToB	examinar?	Other	5 Residence 6 Other (Specify)
	27. Manner of Death 28a. Date of Injury 28t		d. Describe how injury occurred
atio	1 Natural 5 Panding (Monin, Dely Year) 2 Accident investigation	M 1 Yes 2 No	
tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of fnjury - At home, building, etc. (Specify)	, farm, street, factory, office 28	f. Location (Street and Number or Rural Routa Number, City or Town, Stete)
Cer			
Medical Certification:	29a. Certifier (Check only one)  2 Medicaf Examiner: On the basis of axamination and mannar stated.		
N N	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
	1 (00) make 005	DO DAFIE	7/ Soplander 111 2
	Step Welling	a) (Time Print)	10 September 14 20
-	30. Name and address of person who completed ceuse of death (Item 23)	DEVANKIN SAMAN	Daile Patimore marit
State	31. Date filed (Month Dey, Year) 32. Registrar's Signature	Typinal Syllare	The military may be
State gistrar	SEP 1 5 2000   Serve	& Sparks	
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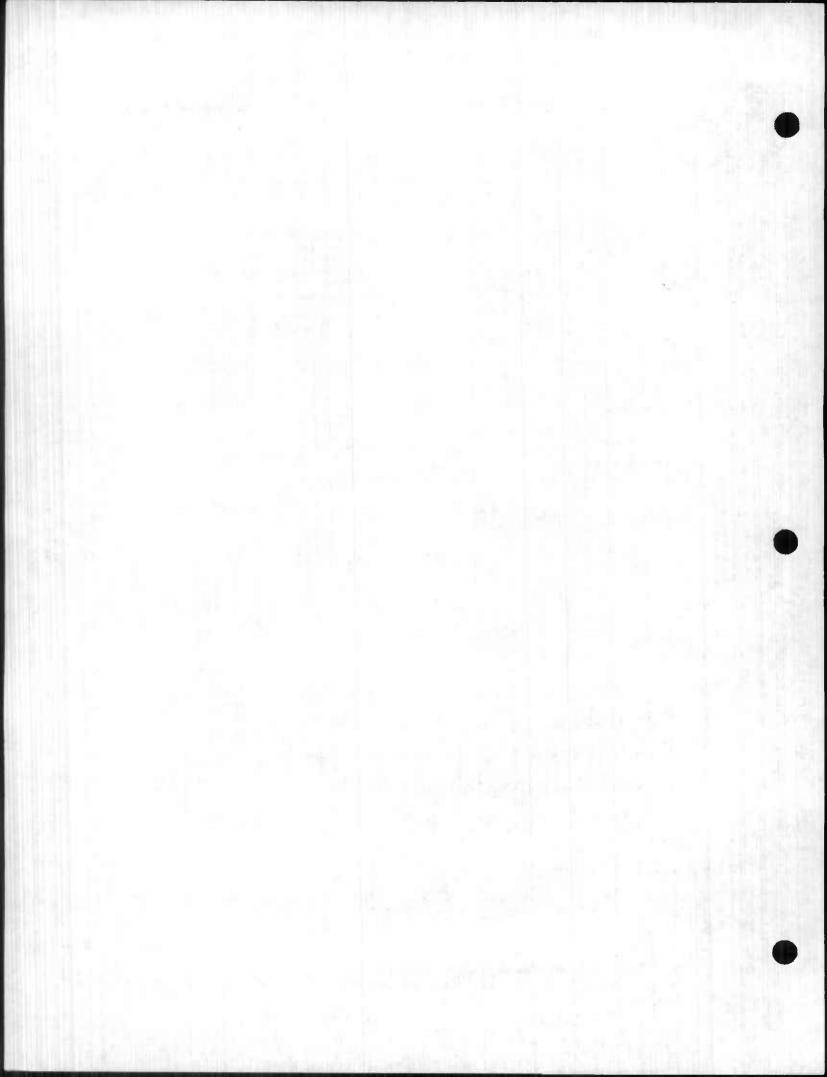


State of Maryland / Department of Health and Mental Hygiene UU

Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Death 3. Time of Death Month Dey SEPTEMBER 9 5 35 PM **Physician** BUE TTNER LILLIAN 2000 /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not Institution, giva street and number) 4c. County of Deeth Examiner St. Elizabeth's Nursing Home Baltimore If Undar 1 Year If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF Months 103 220-46-7817 Yrs. Director 7-12-1897 MD Usuel Residence of Decedent r 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No Yas 2 No Directo N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 21227 U.S.A. 3320 Benson Ave. Funeral is 1 and 2 should be filed within 72 hours after death Art Health and Mental Hygiene. Item 27 in marked other than "natural", or florms 23 other training event, the Medical Engine man 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11 Merital Status 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Nevar Married 2 Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: White by 3 Nidowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondery (0-12) Cotlege (1-4or 5+) Own Home 8 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Elizabeth Lamb William Smith 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m my Inlury or other traum 218 Drum Ave. North Pasadena, MD. 21122 Charles Wagner, Jr. / grandson 20b. Place of Disposition (Name of cometary, crematory or other place)
Glen Haven Memorial Park 9-14-00 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal from State Glen Burnie, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 222 Part Enter the distance or complication, thus caused the shock, or heart feiture. List only one cause on each line. lions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate Interval Between Onsat and Deeth Physician Immediete Cause (Finat diseese or condition resulting in death) /Medical 3 weeks Examiner Due to (or as e consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Dua to (or as a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20(No 3 Probably 4 Unknown Osteoporosis þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Medical Certification: To Be Completed potryroldieni Arteriosclositic Condioverculou disease 1 Yes 1 Yes 2 No 25. Wes case referred to medicat axaminar? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Oulpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Mannar of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how Injury occurred Division or Attending 1 CNetural 5 Pending investigation 1 Yes 2 No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - Al home, ferm, street, fectory, office building, etc. (Specify) 4 T Homicide To the Hospital within 24 hours a To the Funeral C completaly filled Hospital 10 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier September 12, 2000 Keya WID 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print) FERRY RD, BALTIMORE MD-21227 RAJA 4367 HOLLIM 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State SEP 1 5 2000 Registrar

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene 00 29194

		(	Certificate of	Death	F	leg. No.	29194
6	Decedent's Neme (First, Middle, Last)	150 0 11 - 2			2. Date of Dea Month		3. Time of Death
Physician /Medical	Francis Earnest Bush, S	r.			Septemb	per 12,	2000 1945
Examiner	4e Facility Name (If not institution, give street end number 1)	mber)		4b. City, Town, or I	ocation of Death	4c. County o	of Death
	Bon Secours Hospital			Baltimore		n/a	
Funeral Director	5. Social Security Number 6. Sex 1 1 1 1 M 2 □ F	7. Age (In yrs. lest birtho	Months Devs	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey Dec 10,	r, Year)	9. Birthplace (State or Foreign Country) Maryland
pu #_	Usuat Residence of Decedent  10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits
vith the Maryler or 284-1 show be northed at Director	Maryland n/a	Baltim	ore				1 Yes 2 □ No
th with the 23e or 2	10a. Streef and Number 210 S. Payson Street		101. Zip Code 21223		U .	10g. Citizen of W Jnited S	
21215-0020 d within 72 hours after death with the Maryland algene. greaten "patural", or farm 23a or 28a-1 show the factoring the modified and the completed by Funeral Director	11. Marital Status  1 Never Married 2 Merried  1 Never Married 2 Merried  3 Widowed 4 Divorced  12. Was Decardance Frame	2 1 No	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☒ No		pecify Yes or No- p Ricen, etc.)	Biack	- American Indian, , White, etc. White
1 21215-00: led within 72 hours tygiene. her than "natural" nt, me transfer E	15. Decedent's Education (Specify only highest grade completed)	(0	ecedent's Usual Occupative kind of work done	during most of wor	king	16b. Kind of Bus	siness/Industry
within within then.	Elementery/Secondary (0-12) College (1	1-4or 5+)	fe. DO NOT use retire	d)	N		
N pas N	12 0	cra	in operato				nufacturing
Maryland d 2 should be filed th and Mentel Hyg 7 is marked othe traumatic event, To Be C	17. Father's Name (First, Middle, Last)				ne (First, Middle,	Meiden Surname	9)
farylar 2 should be and Mente is marked summific eventering	Cecil Fox Bush  19a. Informant's Name/Relationship (Type, Print)	40h &	lailing Address (Street	Anna Co		City of Town	State Zin Code)
Maryland and a should be file alth and Mentel Hy at the marked other by traumatic event.	Rita M. Bush - wife		S. Payson				
	20a. Method of Disposition	20b. Place of D	isposition (Name of		Date		City or Town, Stata
0 80 = 8	1 Buriai 2 ACremation 3 Removat from 4 Donation 5 Other (Specify)	State	Crematory or other ple	, Inc.	9/14/00	Baltimo	ore, Maryland
Baltim Papemit. Pa Department Important: any Injury once.	21. Signature di Funeral Service Licensee	nk	22. Name and Addre	410	bard Fur 7 Wilker timore,	is Avenu	e
. 7	23a. Part1. Enter the disease, or comblications that a shock, or heert feilure. List only one cause on	aused the death. Do not	enter the mode of dyi	ng, such as cardiac	or respiratory en	rest,	Approximate Interval Between
Physician	0						Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth)	ocardial In:	farction				4 hours
	Tosuming in Gooth)	Due to (or es a cor	nsequence of):				
la sit ed	0	rdiogenic Sl					1 hour
60, be executed ticlen and bunst-transit all Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	nsequence of):				
B7 ete	Cause (Disease or Injury thet initiated events resulting in death) Last	Due to (or as a cor	sequence of):			100	
X 6 Se es	d						
Box death cer death cer attending of for use							
O s state &	Part II. Other significant conditions contributing to de	eath but not resulting in the	ne underlying cause gi	ven in Part I.			tributs to the cause of death?
					101	/es 2∐No	3 Probably 4 N Unknown
ecord  w requir  s been s  s should  pleted					24a. Was perlo	an autopsy med?	24b. Were autopsy findings svailable prior to completion of ceusa of death?
The lew rate has page 2					10 Y	as 2 No	1 ☐ Yes 2 ☐ No
Vital F sician: The certificate lirector, pag	25. Wes case referred to medicel axaminer?			26. Place of Dec	oth (Check only o	ne)	
	Hospital:	Inpatient 2 X ER/Outp	atient 3 DOA	her: 4 Nursing H	lome 5 Resid	lence 6 Othe	r (Specify)
E 5 5 5 0	I TT total of a land	of Injury th, Dey Year) 28b. Tim Inju	iry Wo		28d. Describe h	ow injury occurre	ed
Division of the	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place	of Injury - At home, farm		Yes 2□No			er or Rurel Route Number,
Div Direction	4 Homicide buildi	ng, etc. (Specify)			City or Ton	m, Stele)	
Divisio  To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the ta Medical Certificati	29a. Certifier (Check only one) 1 McCertifying Physician: To the bendman	best of my knowledge, dasis of examinetion and/oner stated.	leath occurred at the ti or investigation, in my	me, date and piace opinion, deeth occu	, end due to the orred et the time,	cause(s) and mar date and piece, s	nner as stated. and due to the cause(s)
ithin of the omple	29b. Signature and title of certifier		29c. Licen	se number		29d. Dete signed	(Month, Dey, Year)
F 5 F 0	10.00	all.	D0029	0068		Senta	402 17 7000
70	30. Name and address of person who completed ceus	se of death (Item 23a) (To		7700		Cp Pen	her 12, 2000
P		00 West Bal		eet, Balt	imore. M	laryland	
State	31. Date filed (Month, Dev. Year) 32. R	egistrar's Signature	book	4			
Registrar	SEP 1 5 2000	eneral D	Jags out				

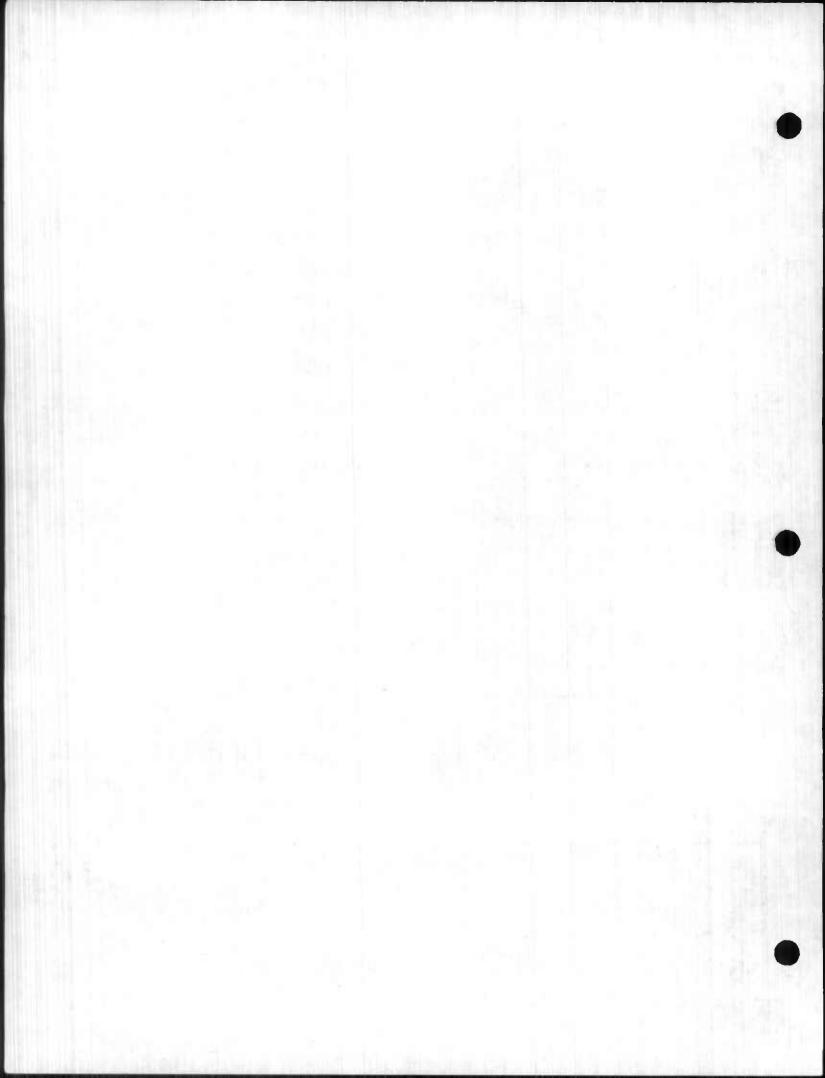
DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 29 | 95

00-3132-3	10						Cert	ificat	e of	Death			Reg. No.					
	_	1. Decedent's Nama (Fi							2. Data of Death Month Day Year  3. Time of Deeth									
	_	Gage Jack	son Car	rter			43					SEPTEM	BER 1	0, 20		5 PM		
	_	4a Facility Name (If not						ocation of Deat		ounty of Dec	eth							
		UNIVERSITY HOSPITAL SHOCK TRAUMA CENTER BALTIMORE CITY N/A																
Funeral Director		5. Social Security Number  215-19-3073  Usual Residence of Decedent						Yrs. Hunder 1 Year Hunder 24 Hrs. 8. Data of (Month)  Nonths Deys Hours Min. May 1						Birth Dey, Year)  2, 1976  9. Birthplace (Steta or Foreign Country)  Maryland				
F 8	1		c. County	9.2	100	. City, Tow	n or Loc	ation							10d. inside	City Limits		
Baltimore, Maryland 21215-0020  the death certificate be assecuted  Example of the ettending physician and important: if then 27 is marked other than "natural", or items 23e or 28a-1 show in the least of the case of the ca	octor	MD	ore							1 ☐ Yes 2 ☑ No								
ath with the 123s or 2 sunt be n	3	302 Wisewel						10f. Zip	27			10g. Citizen of What Country?  United States						
	by Fur	1 Never Married 2 Merried			Yas 2X No				Decedent of Hispenic Origin? (Specify Yes or Its, specify Cuban, Maxican, Puerto Rican, etc.)  Yes 2 No Specify:					No- 14. Race - American Indian, Black, White, atc.  Specify: White				
5-0 72 ho	pete		15. Decedent's Education by only highast grada complated)			16a.	Decedent's Usual Occupation				cina .	16b. Kind	of Businass/Industry					
121	ηble	Elamantary/Secondary (0-12) Collega (1-4or 5+)						(Give kind of work done during most of working life. DO NOT use retired)										
2 wed w		Field Technician Communicati							cion	ion								
BD STEEL	œ l		17. Father's Nama (First, Middla, Last)							-								
Ty day	2		Dennis Duane Carter  19a tnformant's Name/Relationship (Type, Print)  19b						/Stran	1.		ie Loom	Zin Codel					
Ma d 2 s d 2 s T ls an T ls an T ls an		Dennis Duan			0.25													
Te, I have been departed of the second	- 1	20e. Method of Dispositi		er/tath		0b. Place o cemete.	Dispos	tion (Ne	ne of	OL. I	oart.	imore,	20c. Loca	tion - City o	r Town, Stata			
MO Page		1 ☐ Burial 2 ☐ Cri 4 ☐ Don fillion 5 ☐			Stata	len H					i	9/14/20	00 01	D.1.1	endo M	D		
alti martin	1	21. Signature of Fynera	- 1		Λ -	ren n					ty Am1	brose F	upora 1	Home	of In	nadorini		
W FARES		· In	nA	- Nine	M	10						Rd. La:						
	1	23a. Pert1. Enter the di	seasa, or com	plications that o	aused the	death. Do								ie, rie	Approxim	ata		
Di Vital Records, P.O. Box 68760,  hystolan: The law requires that the death certificate be accorded by the extending physician and benefit to the properties of the propertie		shock, or heart fail	lure. List only	one cause on e	ach line.		_1								Onset and	d Death		
/Medical		Immediate Cause (Final disaasa or condition  Med Le Diune																
Examiner	3	resulting in death)		a1	Due	to (or esta	consequ	ance of):	-	700	-	J			1			
7 5	ner		Due to (or esta consequance of): /															
	am	Sequentially list condition	ons,	b	Dua	to (or as a	consequ	ance of):										
SO, e axe sian a curial-		Sequentially list condition if any, leading to immediate. Enter Underlying Cause (Disease or injurity)	g															
876 sate b	dica	that initiated events resulting in death) Last		0.	Due	to (or es a	consequ	ance ot):										
2 0 4																		
Bo ath c	lan																	
that the d	Medical Certification: To Be Completed by Physician/Medical Examiner  To Be Completed by Physician/Medical Examiner	Part II. Other aignificant conditions contributing to deeth but not resulting						in tha underlying ceuse given In Part I.					23b. Did tobacco use contribute to the cause of death?  1 Yes 20 No 3 Probably 4 Unknown					
s been sign													an autopsy rmed?  24b. Were eutop available procompletion of death?		ir to			
	HO											1 DX	Vas 2□	No	Nes 2	□ No		
ital		25. Was cese referred to	o medicet							26. Place	e of Dea	th (Check only	one)					
yalcl direc	ToB	axaminar? 1 X Yes 2 □ No	40.154	Hospitel: 1 🗆	Inpatient	2 ER/O	tpetient	3[X] D	OA Ot	her: 4 N	ursing H	ome 5 Res	idence 6 [	Other (Sp	ecity)			
5 5 5 E		27. Menner of Death	Pending	28a. Date /Mpri	Time of 28c. tnjury at Work?					28d. Describe	c11.5	on						
	cati	2 Accident	Investigation	UIL	0/00	12	12:28 PM 1 Yes 2/2 No					with fixed abject						
or Att freed freed in by	E	3 ☐ Suicide 6 4 ☐ Homicide	detarmined	288. Mace	of Injury - ng, atc. (S)	At homa, fe	rm, stre	et, factor	y, office			28t. Location	(Street end) wn, State)	Number or i	Rurel Aput Nu	torere		
oltal o						71	1-6	-61				7500 K	otch	e low	4/10	9045		
Hoss 24 hoss Fund Hely f	Ca	29a. Cartifiar (Check only one)	Medical Exam	ysician: To the bi	asis of exe	knowledge mination an	d/or inve	occurred estigetion	at tha ti	ma, data an opinion, des	nd place, ath occur	, and dua to the rred et the time,	cause(s) at , date and p	nd mannar lace, and d	as stated. us to the cause	Birst		
thin of the office of the offi	X -	29b. Signature and title	of certifier	end man	nar statad.			29	c. Lican	sa nu <i>m</i> ber	-		29d. Data	signed (Mo	nth, Dey, Year)			
P. N. D. S.		V a forka uno						OCME					SEPTEMBER 11, 2000					
6	-	30. Name and address of person who completed causa of death (Item 23a) (Type, Print)																
		JARO	N W	CKE, M	NO GORIN				eet.	Balt	imor	e, Mary	land	21201				
		31. Date filed (Month, D	ey, Year) 1.5 200		pgistrar's S		4	1	0. 11	,		-,)						
negistra	31	JEF.	200	U	100	/	6	per to	The Stand	1								



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. 96 State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 9-20-2000 JAB Reg. No. AMEND#2 PER MD. G787\_ 2. Dete of Death 8-29-2000 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Day 28 Joseph Chalmers, Jr 2000 8:05 p.m. 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Sinai Hospital of Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) 10 M 20 F Months Days Hours 212-24-9407 74 Yrs. N.C. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 3403 Pinkney Road 21215 U SA 12. Was Decedent Ever in U,S. Armed Forcas? 1 ♥ Yes 2 □ No If Yes, Give Yeer or Detes: 14. Rece - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Specify: Black 1 Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grede completed) Dept of Public Works Elementary/Secondary (0-12) College (1-4or 5+) Superintendent 8th grade N/A 18. Mother's Name (First, Middla, Maiden Sumeme) 17. Fathar's Nama (First, Middla, Last) Joseph Chalmers, Sr Odessa Davis 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3403 Pinkney Road John Chalmers - Son Baltimore, Md 21215 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Steta 20a. Method of Disposition Garrison Forest Vet 9-5-00 Owings Mills, Md of Egneral Service Licensee 22. Name and Address of Fecility
March F/H West 4300 Wabash Avenue Baltimore, Md 21215 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heer failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate vause (Final disease or condition resulting in death) heat doese Arteroscleropic Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of deeth? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en autopsy performed? 1 TYAS 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 Inpatiant Other: 4 Nursing Home 5 Residence 8 Other (Specify)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a State

Director

Funeral

þ

Completed

**Funeral** 

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if them 27 is merked other than "natural", or thems 23s or 28e-1 show any highry or other traumatic event, the Medical Example must be notified at 2006.

Baltimore, Maryland 21215-0020

Physician/Medical Examiner Completed Be Medical Certification: To

by

The lew requires that the deeth certificate be executed optal or Attending Physician: The law requires that the death certificate be execute ours after death.

The second precipies of the this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detected for use as the burisl-tran P.O. Box 68760, Division of Vital Records. To the Hospital of within 24 hours at To the Funeral D completely filled

> State Registrar

29b. Signature and 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Dey, Year)

5 Pending Investigation

6 Could not be determined

1 Yas 2 No

27. Manner of Death

1 Naturel
2 Accident

3 Suicide

29a. Certifier

4 - Homicide

BE GUR 32. Ragistrar's Signeture SEP 1.5 2000

28e. Date of Injury (Month, Day Year)

Mura

2 ER/Outpatient 3 DOA

28b. Time of tnjury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29c. License number

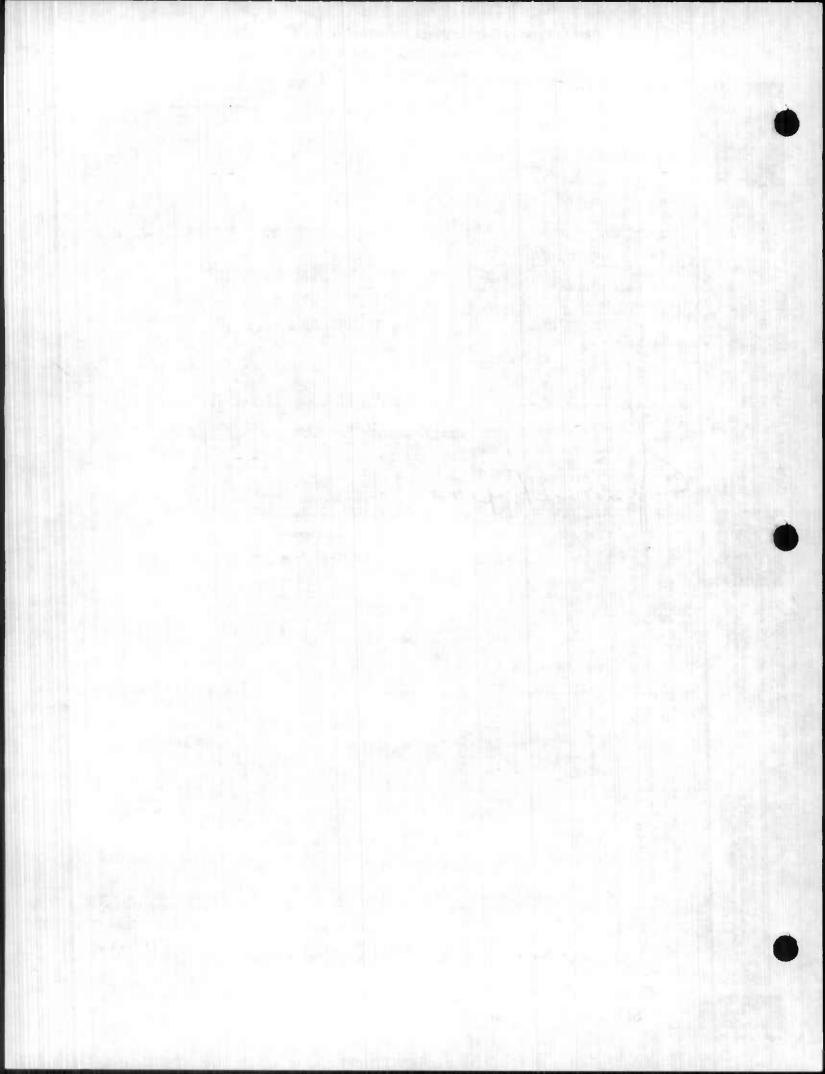
1 ☐ Yas 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

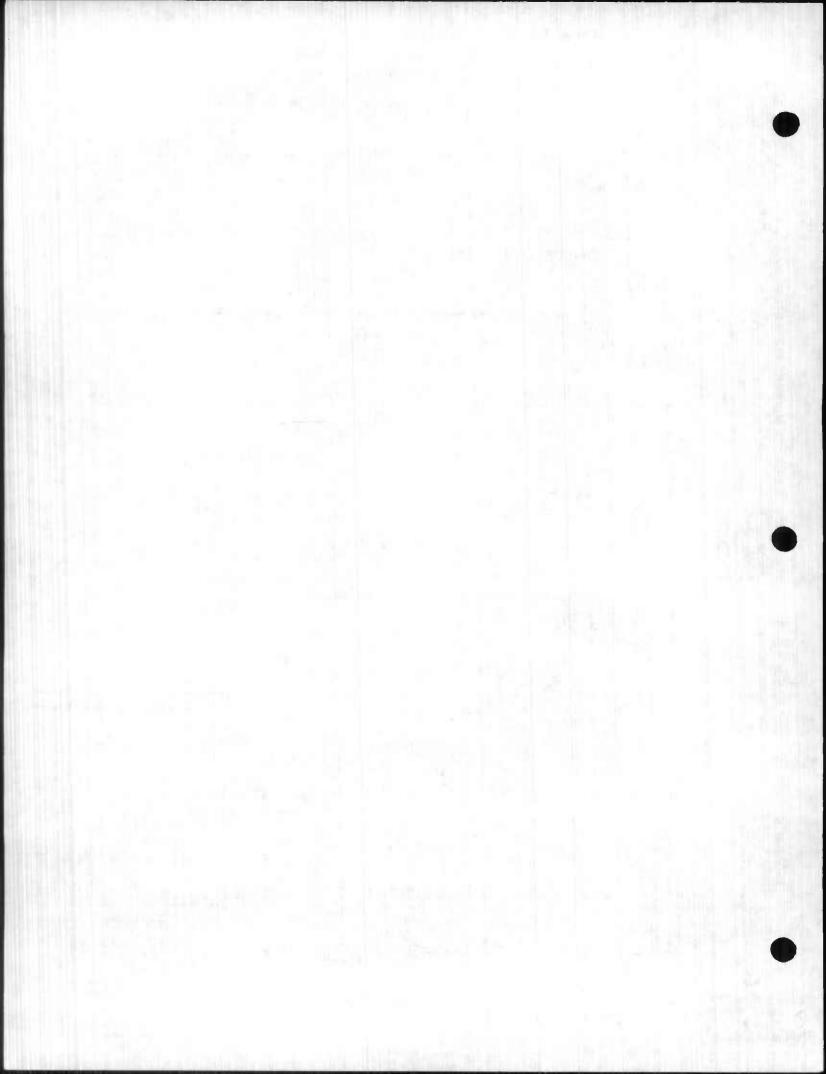
29d. Date signed (Month, Day, Year)

BAUDMD



Amended 1	Ite	m#19b perFH	G787 9/1		of Maryla		artment of F rtificate of		ind Me		iene () ()	2	919	97	
Physicia	_	Decedent's Name     M	e (First, Middle INNIE	, Last)		CC		2. Date of Death Month Day Yea SEPTEMBER 12, 200				of Death			
/Medica	_	4a Facility Name (II		, give street end n	umber)			4b. City, Tov		Location of Death 4c. County of Death					
		MILFORD	MANOR	NURSING	HOME			BAL	TIMOR				ALTIMORE		
Funeral Director				8. Sex 1 ☐ M 2 1 ☐ F	7. Age (In yrs	s. last birthdey) Yrs.	Months Davs		Min.	Date of Birth (Month, Day, MAY 11	Year)	9. Birthpl Count	Birthplace (State or Foreign Country) ENGLAND		
D	-	Usual Residence of 10a. State	Decedent 10b, County		10c. C	City, Town or Lo	cation					10	Od. Inside	City Limits	
death with the Maryland ms 23s or 28s-f show mest be notified at	ō	MD N/A BALTIMORE										1 M Yes 2 □ No			
ith the M or 28e-f	Director	10e. Street and Number 10f. Zip Code								1	0g. Citizen of V	Vhat Country?			
23e o	a	2500 W. BELVEDERE AVENUE #911 21215										U.	S.A.		
Urs after	by Funeral	11. Marital Status  1 ☐ Never Marri  3 🎇 Widowed		Armed I	2 No Sive No		S. 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue) 1 ☐ Yes 2 ☒ No Specify:			Specify Yes or No- to Rican, etc.) 14. Race Black Specify:			e - American Indian, k, White, etc. WHITE		
T- C -	Completed	Elementary/Seco		t grade completed	d) (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most d)	of working						
be filed vital Hygie dother i		6 HOMEMAKER  17. Father's Name (First, Middle, Last)  18. Mother's Na								OWN HOME  ame (First, Middle, Maiden Sumeme)					
E Sabo	o Be	MAX TAYLOR REBECCA									A (UNKNOW				
Maryla d 2 should th end Men 7 is marke traumetic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number							or or Rural F	Route Number	, City or Town,	Stete, Zip	Code)		
2 2 9 2 7		LIBBY DE	EMBO /	DAUGHTER		6103	IVYDENE -	ROAD -		ALTIMORE, MD 21209					
0 80 7 7		20a. Method of Disp 1 Marial 2 ( 4 Donation	☐ Cremation	3 □Removal from	n State	cemetery, crer	sition (Neme of netory or other ple AHAM (AD)		SHURU		20c. Location -	City or To		MD	
Baltim permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC.													
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between													
Physician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting In death)  By Gon (C Bruin 5-Indrome)  Due to (or as a consequence of):													
\$ 5 B	dical Examiner	Cause (Disease or Injury c													
	Physician/Medic														
the death y the etter	sici	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.									obacco uaa cor	ntributa to	the caus	e of death?	
	F.	1	borhi	ruly	r del	design					1 Yea 2 No 3 Probeb				
Records,	Completed by									24a. Was a perfor		CO	ailable prid mpletion o		
Rec The lew ate hes b	d E									100	es 210Mo		death?	□ Na	
= F # & A		25. Was case refer	red to medical					26 Place	of Death /		7/4	1.5	3 1 do 2	_ 110	
Of Vita Physician: this certific	To Be	examiner? Hospital: Other:								ath (Check only one)  Home 5 ☐ Residence 6 ☐ Other (Specify)					
0 = = 0		27. Manner of Death  1 ☑ Naturat  2 ☐ Accident		28a. Dat (Mo	e of Injury onth, Dey Year)	28b. Time of Injury	f 28c. Inju Wo		28	28d. Describe how injury occu					
Division o  To the Hospital or Attanding Ph within 24 hours eiter death. To the Funeral Director: Affer th completely filled in by the funeral	Certification:	3 Suicide 4 Homicide	6 Could determ	ot be 28e. Pla	28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street end Number or Rural Route Number, City or Town, State)				
To the Hospital or within 24 hours effe To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
To th To th comp	×	29b. Signature and title growtifier 29c. License number 29d. Date signed (Month, Dey, Year)												)	
		30. Name and addre	/mw ess of person	who completed ca	RM) use of death (Ite	m 23a) (Type	Print)	169	14/		9/1	2/0	10		
Q		Samu	e Fik	enesh,		055100	1-0	041	in 1	m1/t	s, m	nel			
Stat Registra	_	31. Date filed (Mont	in, Day, Year)	2000 32.	Registrar's Sign	nature &	Spar	Es							
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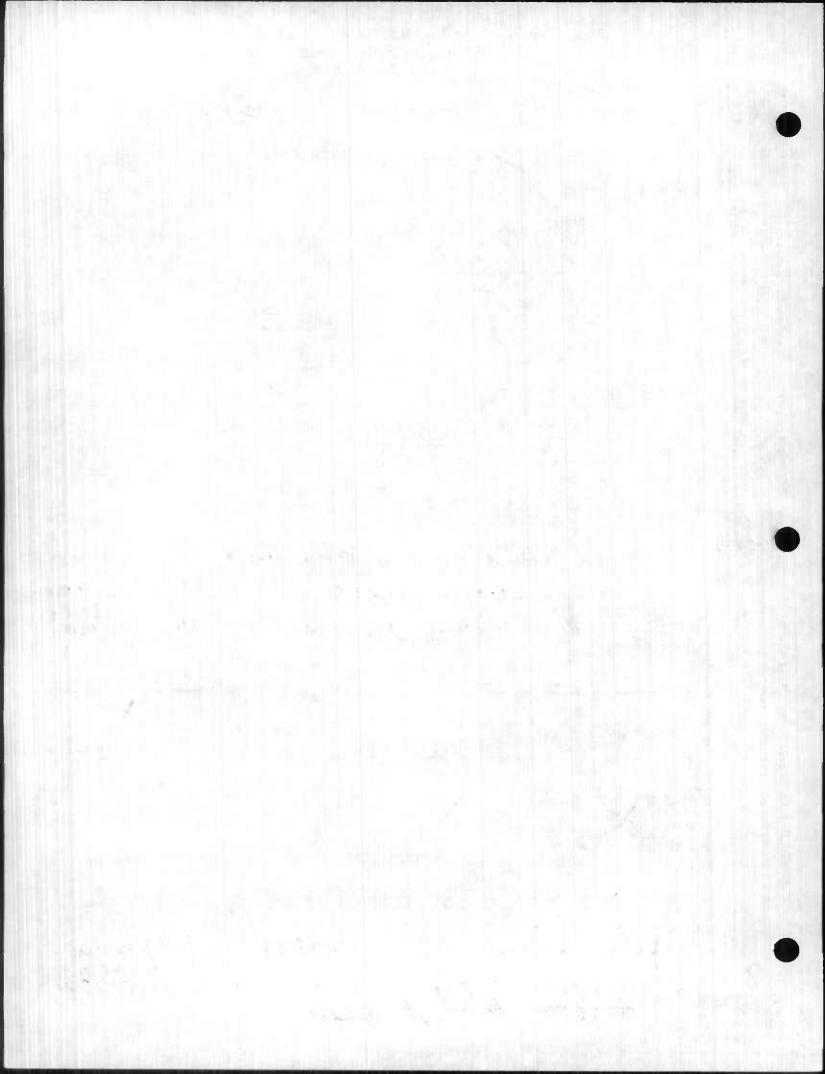


State of Maryland / Department of Health and Mental Hygiene [] [] 29 [ Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2 Data of Death 3. Time of Death **Physician** 1930 Sarah 11 0 2000 /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Examiner NA SECOURS HOSPITA BALTIMORE If Under 1 Yaar | If Undar 24 Hrs. 5. Social Security Number Birthpleca (State or Foraign Country)
 C 6. Sax . Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** 1 M 2 T Months Deys Hours 243 · 36 · 2934 Usual Rasidance of Decedent 88 Yrs. **Director** 10a. Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits 25e-f shov 1 Yas 2 No NIA MD BALTIMORE Directo na Hygieno. el other than "setural", or llenne 23a or 28e-f event, the Medical Examiner mat be notifin 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 3005 LITTLETON ROAD 21216 Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Year or Dates: Was Dacedent of Hispanic Origin? (Specify Yes or No-ff Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Reca - American Indian, Black, Whita, atc. 1 Nevar Married 2 Married 1□ Yas 21 No Maryland 21215-0020 Specify Specify: BLACK ğ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grada complated) Elamantary/Secondary (0-12) LK Collega (1-4or 5+) WK COMESTIC HOME 18. Mothar's Nama (First, Middle, Meidan Sumema) 17. Father's Neme (First, Middle, Last) permit. Pages 1 and 2 should be Department of Health and Mental Important: If them 27 is merked on any Injury or other trauments of the pages. and Mental F JACOB SMITH GRACIE ANN 19a. Informant's Name/Ralationship (Type, Print) 19b. Melling Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) DAUGHTER 3005 LITLETON RD. MARY LEE BALTO MD. 21216 Baltimore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 19-16-00 BALTO. MO MT. ZION CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility VAUGHN C. GRÉENE FUNERAL SERVICE 23a. Part 1. Entécthé diseasa, or complications that caused the death. Do not anter the mode of dying, such es cardlec or respirètory arrest, shock, or haert failure. List only one ceuse on each line. BALTO Approximate Interval Between Onsat and Death **Physician** Immediata Causa (Final diseasa or condition resulting in death) /Medical a. RITS PIR PORTUNES

Dua to (or as a consequence of): Examiner Physician/Medical Examiner DAS attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if sny, laading to immadiata causa. Entar Undarlying Cause (Disaase or injury that initiated evants resulting in death) Last Dua to (or as a consequence of): Box 68760, LUNIC DIS Dua to (or as a consequence of): P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 3 Probably 4 Unknown 1 Yea 2 No Records, þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 TIME 1 Yas 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was casa referred to medical axaminar? Be 26. Placa of Deeth (Check only one) Hospital: 1 Inpatient 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA After this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Neturel 2 Accident 5 Panding invastigation ours after death. eral Director: Af filled in by the fu 1 Yas 2 No 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 3 Suicide 6 Could not be detarmined 28e. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida within 24 hours a To the Funeral D completely filled Hospital edicai 11 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and dua to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) and manner stated. 29a. Cartifiar 29c. Licensa number 29d. Deta signed (Month, Day, Year) 29b. Signature and Ma of certifier ANCHIAMA ROM, LINTINCOM 30. Nama and addrass of person who complated causa of death (ftam 23a) (Type, Print) JOHN SIADVILLS 32. Registrar's Signati C 31. Data filed (Month, Day, Year) SEP 1 5 2000 State

**DHMH 16 Rev 6/95** 

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Physician Month Year 7:55 AM September 11 th, 2000 /Medical 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deals **Examiner** emoria HOSP Hours Min. Month, i nion If Under 1 Year (In yrs. last birthday) 5. Social Security Number 6. Sax 9. Birthpiaca (State or Foreign Country) **Funeral** 10M 2XF Months Days Hours 216-34-0972 Usual Residence of Decedant Yrs Director ano with the Maryland 10a. Stata 10b. Count 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or hems 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 1 Yas 2 No Director Viaryland more 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? vedere dI Funeral deeth 12. Was Decedant Evar In U,S. Armed Forces? 1 Yas 2 YNo It Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, apecify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 14. Race -Race - American Indian, Black, White, atc. permit. Pages 1 and 2 should be filed within 72 hours after o Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or hem any injury or other traumatic event, the Medical Exemples. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 XNo Specify by 3 Widowed 4 □ Divorced a Completed 18a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DQ NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collage (1-4or 5+) 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Malden Surnama) intermant's Name/Ralationship (Type, Print aughter) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) er ams D 20a. Mathod of Disposition

1 Disposition

Cramation 20b. Piace of Disposition (Nama of cematary, crematory or other pla Date 20c. Location - City or Town, Stata 3 Ramovai trom Stata 19/2000 4 Donation 5 Othar (Specify) reenmount Crematory 22. Nama and Addrass of Facility 21. Signature of Funeral Service Licenses Seph 2222 / antar the era Ho Ave. Willor Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, or heart fature. List only one cause on each line. Approximata Interval Between Onsat and Death Physician tmmediata Causa (Final disaasa or condition rasulting in daath) /Medical possible meumenia, Examiner Examiner physician and s the buriei-transit Sequentially list conditions, if any, leading to immadiata cause. Enter Undarlying Cause (Disease or injury that initiated evants rasulting in death) Last Dua to (or as a consequence ot): Disease Rena P.O. Box 68760, Stage Physician/Medical Dua to (of as a consequence of) 98 been signed by the attending should be detached for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Lypertension Records, by 24b. Wara autopsy findings available prior to complation of causa of death? Completed 24a. Was an autopsy performed? page 2 hes 2 XNO After this certificate 1 ☐ Yas 2 ☐ No Division of Vital 25. Was casa refarred to medical Be 28. Placa of Daath (Check only ona) Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) 10 1 Yas 2 No 1 inpatient 2 □ ER/Outpatient 3 □ DOA in by the funerai 27. Manner of Death 28a. Data of injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Tima of 28d. Dascribe how Injury occurred or Attending 1 Naturai 5 Pending invastigation death. To the Hospital or Attendit within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yas 2 ☐ No 2 Accidant 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Piace of injury - At homa, tarm, street, tactory, office building, atc. (Specify) 4 | Homicida the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian edical (Check only one) 29b. Signature and the of certifie 29c. Licansa number 29d. Data signed (Month, Day, Year) M.D September, 30. Name and address of person who complated causa of death (itam 23a) (Type, Print) Baltimore, MD 21218 Union Memorial Hospital, Lu 201 E. University

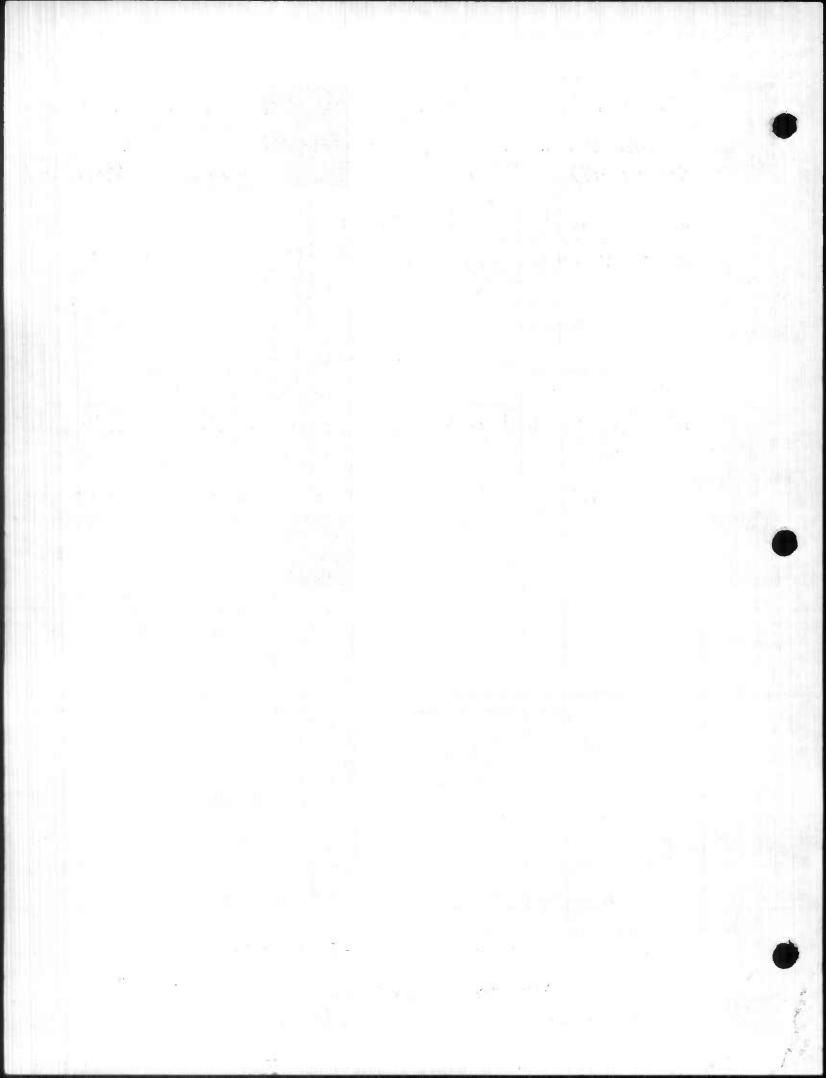
Registrar

State

31. Data flied (Month, Day, Year)

SEP 1 5 2000

32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Dete of Death 3. Time of Death avis Month **Physician** Bessie 4b. City, Town, or Location of Deeth 14,2000 /Medical 4a. Fecility Neme (If not Institution, give street and number) 4c. County of Deeth **Examiner** St. Elizabeth's Nursing Home Baltimore Hunder t Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)

June 25, 15 5. Social Security Number 7. Age (In yrs. last birthday) 85 Yrs. Birthplace (State or Foreign Country) **Funeral** 1□ M 21 F 212-018676 1915 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Maryland N/A Baltimore 1 Yes 2 □ No Director 28a-4 10e. Street and Number 1937 Deering Ave. 10f. Zip Code 10g. Citizen of What Country? ð must be 21230 United States horns 23a Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ BNo tf Yes, Giva Year or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Bleck, White, etc. 11. Maritel Stetus 1 Nevar Married 2 Married b 1 Yes 2 No Spacify: Specify: by 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home with and Mental He-17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maidan Surname) James Bowman Julia Berwager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, State, Zip Code) important if hen 27 is a Ed Monath P.O. Box 96 Mc Sherrystown

20b. Place of Disposition (Name of cemetery, crematory or other place)

Pennsylvania 17344

20c. Location - City or Town, State 20e. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Westminster, MD. St. John's Evang. Cemetery 09/19/00 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Feclify
Ambrose Funeral Home 1328 Sulphur Spring Road 21. Signature of Funeral Spice Licenses Arbutus, Maryland 21227

with. Do not anter the mode of dying, such as cardiac or respiretory arrest, 23a. Pert1. Enter the disease, or complications that caused the shock, or heart failura. List only one cause on each line. **Physiclan** Intracranial bleeding /Medical Immediata Ceuse (Final disease or condition resulting in death) Examiner Uyberteas, on Examiner Sequentially list conditions, if eny, laading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in daath) Lest buriel-tren be execu Physician/Medicai the Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. D.0 23b. Did tobacco use contribute to the cause of death? 1 Yee 21 No 3 Probably 4 Unknown signed t Records. þ 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of ceuse of death? 1 Yes 2 No 1 ☐ Yes 2 No certificate Division of Vital or Attending Physician: after death. 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1□ Yes 2□ No Other: 4 Nursing Home 5 ☐ Rasidance 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accidant Director: 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 4 Homicide • Funeral Di Hospitai 29a, Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to tha cause(s) and manner as stated. Medical npletely (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and many stated. To the To the Comple 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 00052746 Sept., 15,2000 30. Name and addrass of person who complated ceusa of daath (Itam 23a) (Type, Print)

Yelena Lipnik, 720 Maiden Choice Lane, Ralbinore 21228

31. Data Illad (Month, Day, Year)

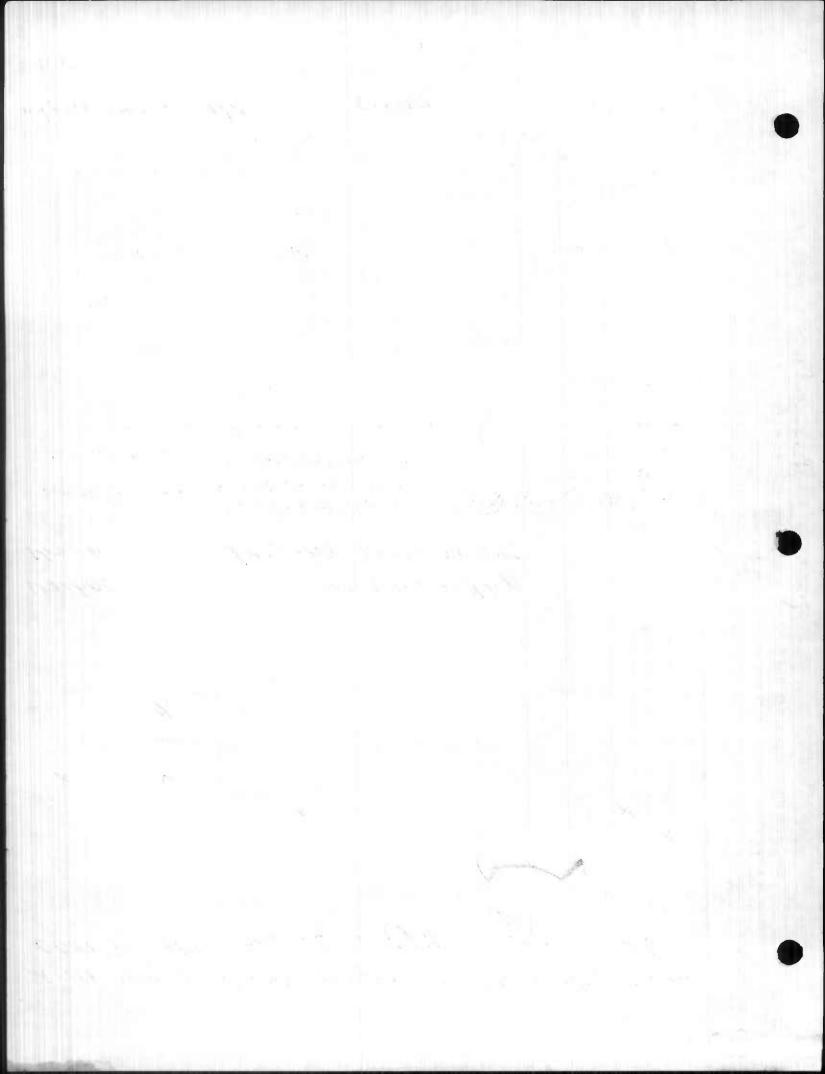
32. Registrar's Signatura

State Registrar

**DHMH 16 Rev 6/95** 

SEP 1,5 2000





Birthpleca (Stata or Foreign Country)

10d. Inside City Limits

Approximate Intervat Batween Onsat and Death

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Maryland

White

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State of Maryland / Department of Health and Mental Hygiene U KAYMUND LIKO DREWRY Certificate of Death Reg. No. 2. Data of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) Day Month **Physician** Raymond Leo Drewry, Sr. 12, 10:25 AM SEPT.

/Medical Examiner

/Medical Examiner and attending physician for use as the buria should be detached 5 peeu page 2 this certificate Affer Director: A

4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death AUTHORITY DRIVE, KEY BRIDGE DINDALK BALTIMORE If Undar 1 Yaar | If Undar 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthdey) 8. Data of Birth (Month, Day, Year) **Funeral** Days 12 M 20 F 47 218-58-9056 Sept. 11,1953 Director Usual Rasidence of Decedant 10a. Stata 10c. City. Town or Location 10b. County 28a-f show Essex Maryland Baltimore Directo idical Examiner must be notifie 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? b 21221 22 Tulip Tree Court Barns 23a United States Funeral 12. Was Decedent Evar in U,S.
Armed Forcas?
1 ☐ Yas 2 ☑ No
If Yas, Giva
Yaar or Datas: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) Black, Whita, alc. 72 hours after 1 Nevar Married 2 Married 8 21215-0020 1 Yas 2 No Specify: Specify: P 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry filed within al Hygiene. the Me Elementary/Secondary (0-12) Collega (1-4or 5+) 11 Years Traffic Installer Baltimore City Maryland 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Meidan Sumama) should be Mental and Mental George Leo Drewry Louise Jamerson 19a. Informant's Name/Ratationship (Type, Print) (Son) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) Pages 1 and 2 s ment of Health an Mr. Raymond L. Drewry, Jr. 22 Tulip Tree Ct. Essex, Maryland 21221 Health Hern 27 Saltimore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) important: if its any injury or off once. 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☑ Cramation 3 ☐ Removal from Stata Hilltop Service Corp. 9/18/2000 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Shoulum of Funaral Sarvice License 7922 Wise Ave. Dundalk, Maryland 23. Paul Find fine disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. **Physician** tmmediata Causa (Final Multiple Injuries disease or condition resulting in death) Physician/Medical Examiner The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury Dua to (or es a consequence of). 68760 that initiated events rasulting In death) Last Dua to (or as a consequence of): Box Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. atheroschrotic Caroliovascular disease py of Vital Records, Completed 24a. Was an autopsy performed? Depression 1 Yas 2 □ No or Attending Physician: after death. 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only one) Hospitat: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 No Yes 2 No Medical Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Deta of Injury (Month, Day Year) 28b. Time of Division 1 Netural 5 Pending 1 Yas 2 No invastigation 9-12-2000 2 Accident 1021 6 Coutd not be determined 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b 4 Homicide Kex Bridge 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a, Certifier (Check only one) 29b. Signatura and title of certifie 29c. Licansa number O.C.M.E M.P. 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

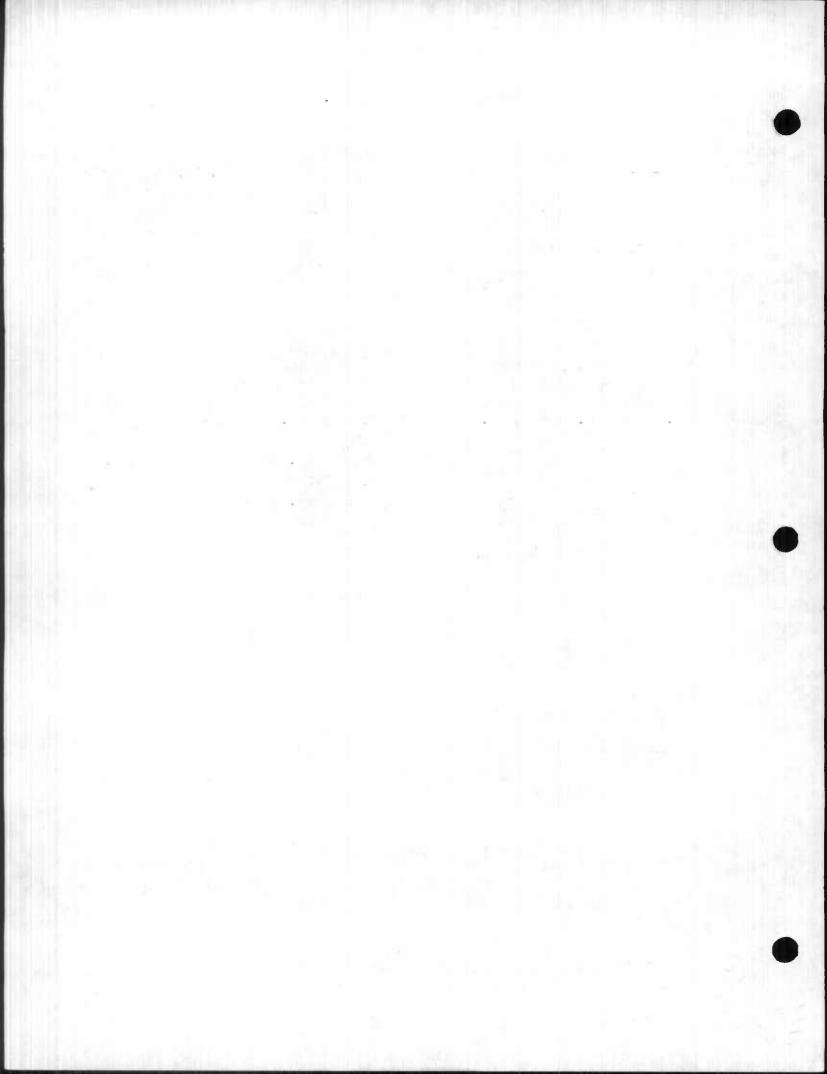
23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings completion of causa of death? 1 X Yes 2 No Other: 4 Nursing Homa 5 Residence 6 X Other (Specify) AT SCENE 28d. Describe how injury occurred subject jumped from bridge Location (Street and Number or Rural Route Number, City or Town, Stete) Rey Bridge Baltimore County, Maryland 29d. Data signed (Month, Day, Year) SEPT. 13, 2000 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signatura books **ORIGINAL** 

Registrar

Stephen S,
31. Deta filed (Month, Dey, Year)

SEP 1 5 2000

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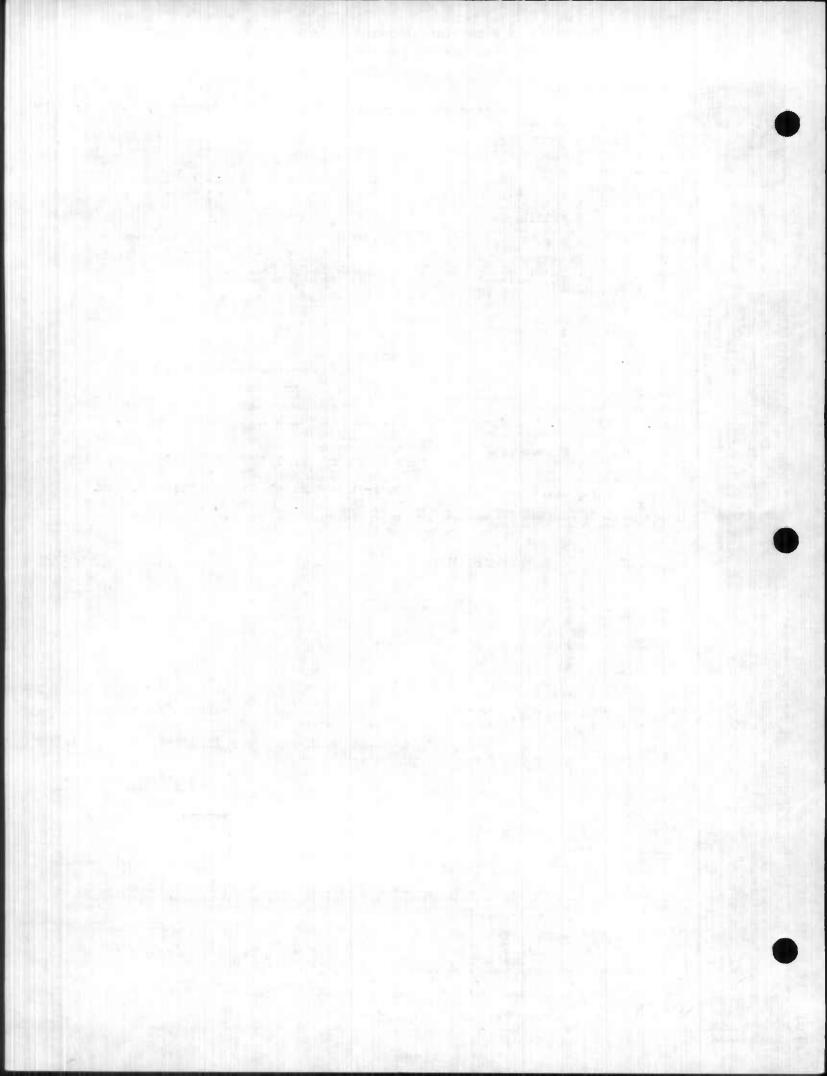


State of Maryland / Department of Health and Mental Hygiene

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	amend item	26 per phys G787 9/15/0	00 yf	Certifica	te of Death	Reg	J. No.	29202		
	<b>8</b> 1 - 1 - 1 - 1	1. Decedent's Name (First, Middle, Las	1)			2. Date of Death Month	Day Yea	3. Time of Death		
	Physician /Medical		Margar	et Genevie	ve Daffron		per 8, 20			
	Examiner	4a Facility Name (If not institution, give	street and number)		4b. City, Town, or L	ocation of Deeth	4c. County of D	eath		
		8249 Lexington Da	rive		Severn		Anne Ai	rundel		
	Funeral Director	5. Social Security Number 6. Se 217-50-0001	7. Age (In yrs	s. last birthday) If Unde Months	or 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Y Jan. 4,	'ear) 9. E	Birthplace (State or Foreign Country) Maryland		
	2 .	Usual Residence of Decedent	100	Sh. Your or Location				10d toolde City Limite		
	25a-1 shorn additing at rector	Maryland Ba	1timore	City, Town or Location	Edgemere			10d. triside City Limits 1 ☐ Yes 2 ☑ No		
	E 20 0	10e. Street and Number 7819 North Cove	Road		21219		United S	States		
21215-0020	ours after death of the control of t	11. Merital Status  1 Never Merried 2 Merried  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2√2No If Yes, Give Year or Dates:		edent of Hispanic Origin? (Specify Cuben, Mexican, Puerto 20 No Specify:	ecify Yes or No- Ricen, etc.)	14. Race - A Black, W Specify:	merican Indian, Inite, etc. White		
5-0	ad within 72 ho ygiene. wr than "naturn it, the Medical.] Completed	15. Decedent's Ed (Specify only highest grad		16a. Decedent's Usi	ual Occupation	ina 16	b. Kind of Busine	ss/Industry		
21	un and Idu	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	ork done during most of work use retired)					
2	Cor the	11 Years		Homemake			Own Hon	ne		
Pu	B TOPE	17. Father's Neme (First, Middle, Last)				e (First, Middle, Ma				
yia	Mental Me	Martin Moran		et Ann Cu	nninghan	n				
Maryland	2 sh and and and and and	19a. Informant's Name/Relationship (7			s (Street and Number or Rui			e, Zip Code) e, KY 40067		
	a and a sund	Mrs. Patricia A.			ernry Smith R					
altimore,	Pages 1 nant of H ant: If Ne ary or oth	20a. Method of Disposition  1CXBurial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	Place of Disposition (Na cometery, crematory or ak Lawn Cem	other place)		Baltimor	or Town, State		
Balt	Departimports any injurial	21. Signature of Funeral Service Licen	See 46	Duda-	nd Address of Facility Ruck Funeral Wise Ave. Du					
		23a. Part1. Shter the disease, or comp shock, or heart failure. List only	olications that ceused the de	ath. Do not enter the mo	de of dying, such as cerdiac	or respiratory arres	t,	Approximate Interval Between		
4	Physician	SHOCK, OF HEART FAILURE. LIST ONly C	one cause on eech line.					Onset end Death		
	/Medical	Immediate Cause (Final disease or condition	· Preumor					2 days		
	Examiner	resulting in death)		(or as a consequence of	١٠			Jauge		
	e manual		200 10	(0. 6.5 6. 001.50 (0.01.50 01	,					
o,	be executed sicien and burial-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events	b. — Due to	(or as e consequence of	):					
68760,	g physas the	Cause (Disease or injury that initiated events resulting in death) Last	CDue to	(or es a consequence of	:					
Box	attendin for use	d.								
	the death cer y the attendir ached for use hysician/N	Part II. Other significant conditions of	ontributing to death but not re	esulting in the underlying	cause given in Part I.	23b. Did tob	acco usa contrib	oute to the cause of death?		
., P.O	es that the de igned by the be detached by Physic	Dementia	Malnutritie	eh .		1 🗆 Yas	2000 3E	Probably 4 Unknown		
Vital Records,	nequir nean s hould					24a. Was an performe		tb. Were autopsy findings available prior to completion of cause of death?		
E	sician: The law sirector, page 2 s irector, page 2 s					1 ☐ Yes	2 0 No	1 □ Yes 2 No		
tal	entifica sctor, p	25. Was cese referred to medical			26. Place of Dea	th (Check only one)	)			
>	Physician: this certific ral director.	examiner?	Hospital:	☐ ER/Outpatient 3☐ D				son's Specify)residence		
Division of	2 2 2	27. Manner of Death  1 Death  1 Death  1 Death  1 Death  1 Death  1 Death  1 Death  1 Death  1 Death  1 Death  1 Death  1 Death	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how		residence		
Divis	in or Attendi strendesth. Director: A d in by the t	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, street, factority)	ry, office	28f. Location (Stre City or Town,		r Rural Route Number,		
	To the Hospital or Attending P within 24 hours after deeth. To the Funeral Director: After the completely filled in by the funeral Medical Certification:				d at the time, date and place, n, in my opinion, death occur					
	To the round of th	29b. Signature and title of Aprillion		2	9c. License number	290	d. Date signed (M	Ionth, Day, Year)		
	0/	D FULL	MD		D 389 CE	-	9/11/2	900		
	()	30. Name and address of person who o	completed cause of death /the	em 23a) (Type, Print)	000/00		1 / 1 /			
		Dulipit Civil	Gethe 1413	Annahat	Road HELD	& orlow	ton MD	21113		
	State	21 Day (filled (Month, Day, (Year)	32. Registrar's Sig	nature ,	NAY TIVE	- were	EN TO	בוודט		
	Registrar	SEP 1 5 2000	reneway &	Louks						

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Please Type or Print in Black Indelible ink. Assure Ail Copies Are Legible. Amended Item#21 perFD G787 9/20/2000 EW State of Maryland / Department of Health and Mental Hygiene Amended Item#25,26,27 perPHYG787 9/15/2000 EW Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Deta of Deeth 3. Tima of Death Month Year **Physician** Aug.

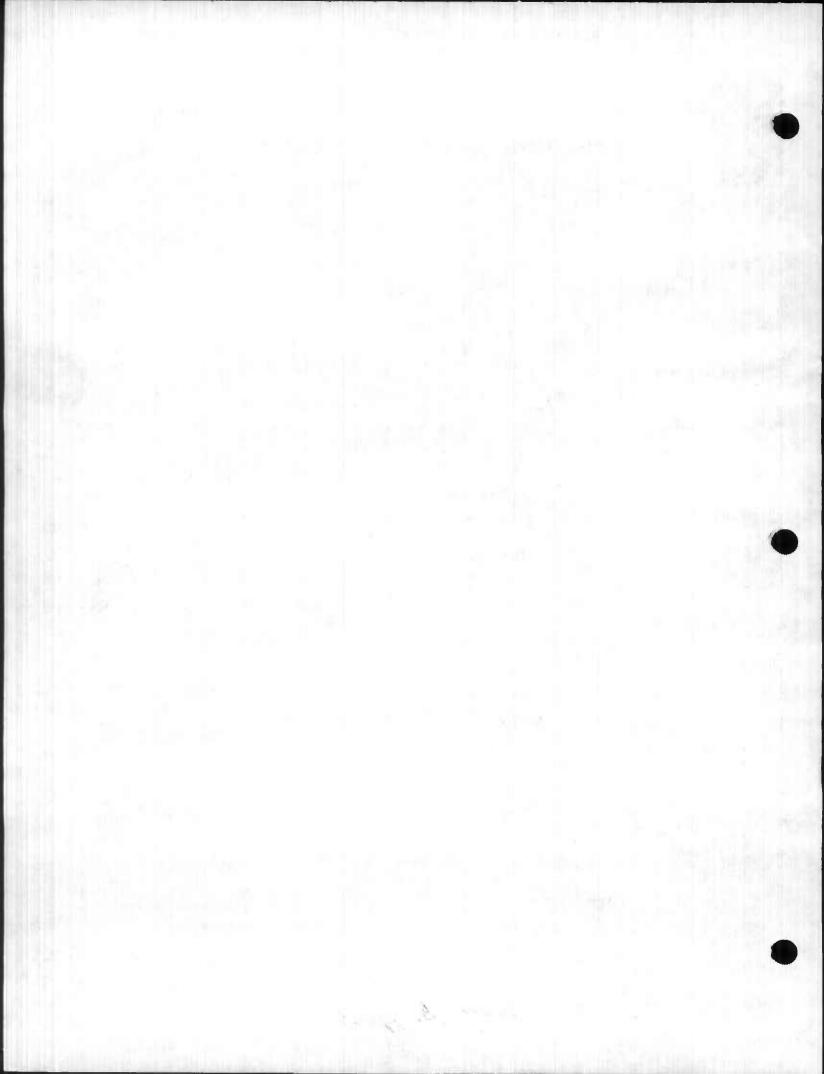
4b. City, Town, or Location of Death ElnoRa DRUIN GEORGE 8:20 Pm 3 2000 /Medical 4e Facility Name (If not institution, give street and number, 4c. County of Death Examiner Maryland Hospital Southern linton PRINCE GEORGE If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) 5. Social Security Number If Undar 1 Yaer Birthplaca (Stata or Foraign
 Country) **Funeral** 89 Months Days 1□M 20 F NOV. 15, 1910 VIRGINIA 229-01-4606 Director Usuai Rasidance of Decedant the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Insida City Limits 28s-f show traumetic event, the Medical Examiner must be notified at 00 1 Nes 2 No Director PRINCE GEORGE MORNINGSIde 0 00 10e. Street and Number Of. Zip Code 10g. Citizan of What Country? 8 20746 215 A 6808 Woodland Rd. Rema 23a Funeral 14 Raca - American Indian 11. Marital Status 12. Was Decedant Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married Maryland 21215-0020 "natural", or 1 ☐ Yas 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada completed) other than Elementery/Secondary (0-12) College (1-4or 5+) Hygiena. own Home Homemaker 12 18. Mother's Nama (First, Middla, Maiden Sumama) 17. Fathar's Name (First, Middle, Last) Be 2 should be f n end Mental I is marked of Nicholas GEORGE Annie Ella Fugua 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19e. Informent's Name/Ralationship (Type, Print) permit. Pages 1 and 2 sh Department of Health end Important: If Item 27 is in eny Injury or other traum page. Woodland Rd. -Daughter 6808 Sandra Hatcher Baltlmore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Buriel 2 □ Cremation 3 □ Removel from State Aug.16 Richmond Rich. Va Oakwood Cem. 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Fecility NELSEN FUNERAL HOME 4650 S LABURNUM AVE 23231 RICIL VA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Set Onset and Death **Physician** Immediete Cause (Final disaasa or condition rasulting in deeth) /Medical Examiner Dua to (or as a consequence ot): Examiner per Tension Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last attending physician for use as the bune ar Kinsons disease Physician/Medical Due to (or as e consequence of) scular disease 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yss 2 No 3 Probably 4 Unknown Completed by NOTA 24b. Wara autopsy findings 24a. Was an autopsy available prior to completion of causa of death? performed? this certificate has 2 No 1 Yas 1 ☐ Yes 2 ☐ No 25. Was casa rafarred to medical Be 26. Placa of Deeth (Check only ona) Drain, Othar: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No Certification: To 1 Inpatiant 2 ER/Outpetient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 27. Mennar of Death 28b. Tima of s efter death. Division 1 Natural Injury 5 Panding 1 Yas 2 No invastigation 2 Accident 6 Could not be datermined 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At homa, farm, street, factory, offica building, etc. (Specify) 4 Homicide ò To the Hospital within 24 hours To the Funerel I 29a. Cartifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, deta and plece, and due to the cause(s) end manner stated. (Check only one) 29b. Signature and title of cost 29c. Licansa number 29d. Data signed (Month, Day, Year) MD D0052 999 anundel 30. Nama and address of person who compiated cause of death (Item 23a) (Type, Print) CLINTON A. KAHIMIAN 7801 AVE BRANCH 31. Dete tiled (Month, Day, Year) 32. Registrer's Signature AUG 2 2 2000

Registrar

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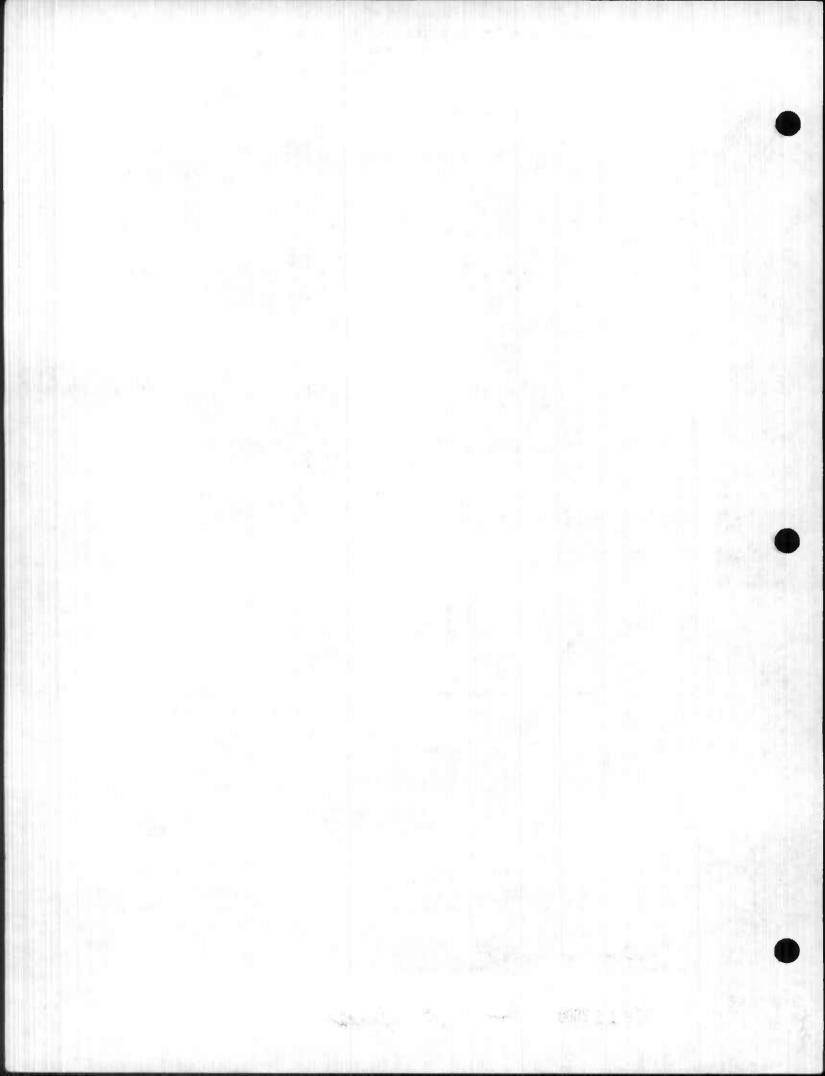
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			Certificate of	Death		eg. No.	
Physician /Medical	1. Decedent'e Name (First, Middle, Last,		Ī	auis	2. Data of Dea Month September	Day Yea	1000
Examiner	4a Facility Name (If not institution, give	. /		4b. City, Town, or L	0	4c. County of De	eath 4
Funeral	Social Security Number     6. Security Number	7. Age (In yrs. lest birth	hday) If Under 1 Yaar Months Deys		8. Date of Birth (Month, Day		Sirthplace (State or Foreign Country)  W. C
Director	240-38-6588 Usual Residence of Decedent	70			MAY 29	193	70.0
th with the Maryland 23a or 28a-f ahow ast be northed at	10a. State 10b. County  M.D. V/A	10c. City, Town	or Location	=			10d. Inside City Limits 1. ☐ Yes 2 ☐ No
the Mi	10e. Street and Number		10f. Zip Code			log. Citizen of What	Country?
th with 23a or set be a Dis	601 CENTI	eal	2/2	01		USA	
20 s after dea		12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:	13. Was Decedent of If Yes, specify Cub	oan, Mexican, Puerto	pecify Yes or No- Rican, atc.)	Black, W	merican Indian, hite, etc.
5 2 E			Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of work	ring	16b. Kind of Busine	
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Nore, Maryland 212: ges 1 and 2 should be filed within t of Health and Mental Hygiene. If them 27 is marked other than or other traumatic event, the Langer of the Free Comp	17. Father's Name (First, Middle, Last)	700	TOOK AL		e (First, Middle,	Meiden Sumeme)	
should be filed and Mental Hygi marked other mette event, To Be Co	SAMDSON P.	ATTERSON		SALL	y Ad	AMS	
Maryland d 2 should be file to and Mental Hy 71e marked oth traumatic event To Be (	19e. Informant's Name/Relationship (T)		Meiling Address (Stree				e, Zip Code)
1 and 2 Health am 27 in	ANITA BRO	WN 32	11 GYNNS	FALLS	Pwy B	PALTO MD  20c. Location - City	2/2/8
Ore, as 1 as of Hear	20a. Mathod of Disposition  1 Burlal 2 Cremation 3 DF		Disposition (Neme of y, cremetory or other ple	9C0)	, ,		
Pag Pag ury o	4 Donation 5 Other (Specify)		ZION		9/16/2000	LANdsd	own mo
Baltimore permit. Pages 1: Department of He important: if item any injury or oth page.	21 Signature of Funeral Service Licens	Bella	22. Name and Addr				PAL Home
Physician /Medical Examiner	shock, or heart failura. List only of immediate Cause (Final disease or condition resulting in death)	a. Acute Re		Ry I	)ISTRE	ss Syndi	Interval Batween Onsel and Death
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he lay	25. Wes case reterred to medical			26. Place of Dea	th (Check only o	ne)	
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Of VIta Physician: this certific al director. To Be	25. Wes case reterred to medical axaminar?  1   Yes   2   No    27. Menner of Death 1   Netural   5   Pending investigation 3   Suicida   6   Could not be determined  29a. Certifier   12   Certifying Physical Axaminary   12   12   12   12   12   12   12   1	28a. Dete of Injury (Month, Day Year)  28e. Place of Injury - At home, fai	ime of njury M 28c. Injury M 1 [28c. Injury W W 1]	ther: 4 Nursing H ury at ork? Yes 2 No	28d. Describe h 28f. Location (S City or Tow	Street and Number of m, Stete) cause(s) and menna	Rural Route Number,
JVISION OT VITE or Attending Physician: ther death. Director: After this certific in by the funeral director. ertification: To Be	25. Wes case reterred to medical axaminar?  1	28a. Dete of Injury (Month, Day Year)  28b. T 28b.	rm, street, fectory, office  , death occurred at tha tallor investigation, in my	ther: 4 Nursing H ury at ork? Yes 2 No	28d. Describe h 28f. Location (5 City or Tow , and due to the cred at the lime,	Street and Number of m, Stete) cause(s) and menna	Rural Route Number, r as stated. due to the cause(s)
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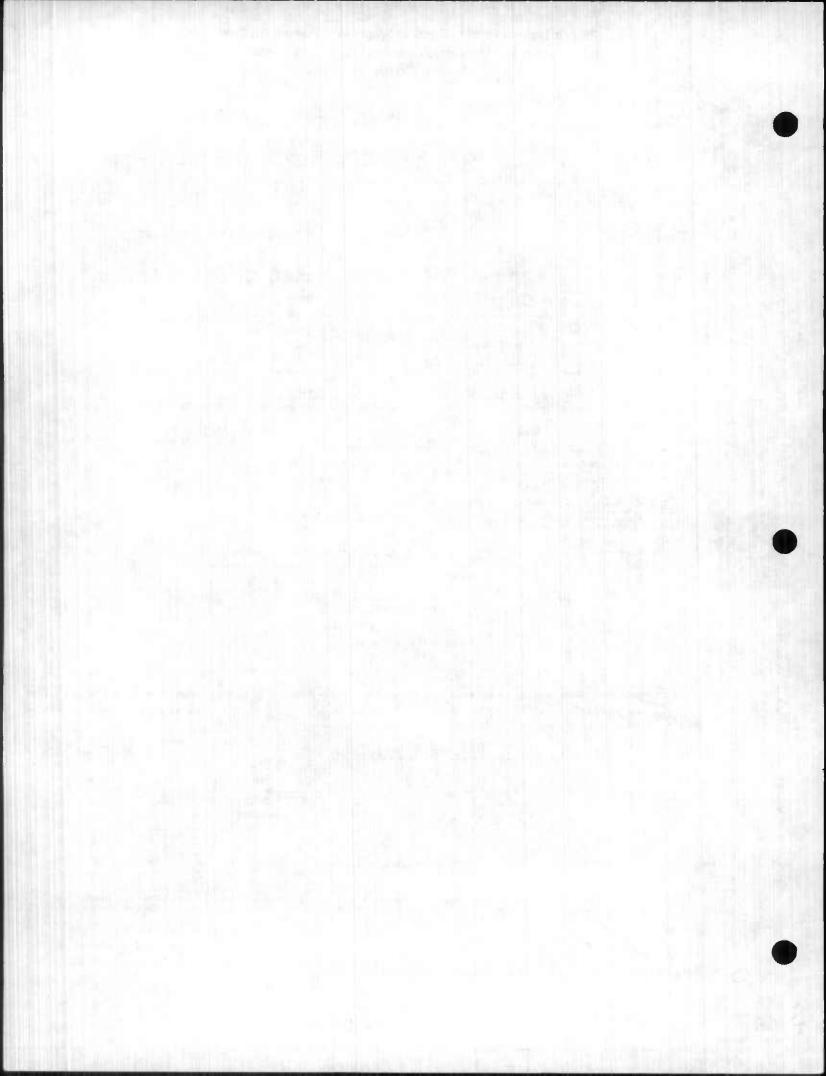
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Phys	ician	1. Decedent's Name (First, Middle, La	St)	V.		2. Date of De Month	Day	Year	me of Death
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Exam	niner	Union Memorial Ho			Baltim			N/A	
Funer Directo		216-53-12101	ex	Yrs. If Und Month	er 1 Year If Under 24 Hrs s Days Hours Min.		28,1998	9. Birthplace (S	tate or Foreign
Maryland of show		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Location			· ·	10d. Ins	Ide City Limits
h the Marylan r 28a-f ehow Inotified at	ctor	Maryland N/	A	Baltin	nore			15	Yes 2□No
豆 0 克	Directo	10e. Street and Number	I D	10f. 2	tip Code		10g. Citizen of V	Vhat Country?	
€ 2 4	Funeral	11. Marital Status	12. Was Decedent Ever in U	7,S. 13. Was Dec	edent of Hispanic Origin? (Specify Cuban, Mexican, Puer	specify Yes or No	- 14. Rec	e - American Indi	an,
7 2 22	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		2DNo Specify:	to Rican, etc.)	Biac BigGcity	can Ar	nericar
21215- 1 within 72 plene. r than "nat	Completed	15. Decedent's Ec (Specify only highest gra		16a. Decedent's Us (Give kind of v life. DO NO7	vork done during most of wo	rking	16b. Kind of Bu	usiness/Industry	
be filed tal Hygh d other avent, p	Be	17. Father's Name (First, Middle, Last)	- 1 1-		18. Mother's Na	me (First, Middle,	, Maiden Sumam	(e)	To East
Maryiand d 2 should be file th end Mental Hy 7 Is marked oth traumatic avent	To	19a. Informact's Name/Relationship (	Lubanks	J C.	iss (Street and Number or A	LI VC	er City or Town	State Zin Code	on
Fe, and Heel Heel		MS, Ragulya  20a. Method of Disposition  1 Burial 2 Cremation 3 C	Johnson 200. I	Place of Disposition (A cemetery, crematory o	Burnwi place) D. V.	9/19/2000	d. Bo	City or Town, St	1.21239
Baltimo permit. Page Department of Important: If any Injury or		4 Donation 5 Other (Specify 21 Signature of Funeral Service Linear		1	and Address of Facility	. 7000	Dall	D. 1410	
Bait. Departiments	DUC	De Caronh	L'ALL	11 Jose	ph L. Rus	SFU	Beral t	tome.	216
		23a. Part Fiter the disease, or com show or heart failure. List only	plications that caused the dear one cause on each line.	th. Do not enter the m	ode of dying, such as cerdia	c or respiratory a	rrest,	Interv	eal Between
Physicia /Medica Examine	al 💮	Immediate Ceuse (Final disease or condition resulting in death)	a. CORONARY ARTI	TRY ANOMALY	d):			Onse	t and Death
D =	iner		h		*				
60, be axecuted ician and burial-transit	ai Examin	Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury	Due to (c	or as a consequence o	ŋ:				
Box 68760, deeth certificate be an ettending physician of for use as the buria.	√Medicai	that initiated events resulting in death) Last	Due to (c	or as a consequence o	():				
O. Bo ne deeth the etter thed for u	Physician/Me	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlying	ceuse given in Part I.	23b. Dld	tobacco use co	ntributa to the c	ause of death?
P. hat the delay delay	by Phy	COMPLICATIONS OF	PREMATURITY			10	Yes 2 No	3 Probably	4 🗆 Unknown
ew requires been 2 should	Completed b					24a. Was	an autopsy ormed?	24b. Were aut available complets of death?	prior to on of cause
= F # 8	Сош					火	Yes 2□No	V Yes	2 No
Of Vital In Physician: The this certificate rai director, pag	Be	25. Was cese referred to medicel examiner?	Hospital:	*****	Other:	ath (Check only			
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Division To the Hospital or Attending I within 24 hours after death To the Funeral Director: After completely filled in by the funes	Certification:	1 Naturel 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined		Injury M	1 ☐ Yes 2 ☐ No		Street and Numb	per or Rural Rout	e Number,
DIVISION To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	I Cert		ysician: To the best of my kno	1900000	ad at the time, date and place			anner se steler	
n 24 h e Fun detaly	edicai		niner: On the basis of examinations and manner steted.	ation and/or Investigati	on, in my opinion, death occ	urred et the time,	date and place,	and due to the c	lusa(s)
To the within 2 To the comple	Z	29b. Signestre and title of certifier	. 0		9c. License number O.C.M.E.			d (Month, Day, Y	
		Cartok	eur		O.C.M.E.		septembe	r 14, 20	700
		T 0 ()	completed cause of deeth (Itee	m 23a) (Type, Print) 111 Pe	nn Street, Ba	ltimore	Marvla	nd 2120	
Sec.	tate	31. Date filed (Month, Day, Year) SED 1 5 2000	Registrar's Sign				, , , , , ,	-220	



			Cen	ilicate (	JI L	Jealii			Reg. No.		
nysician Medical	Decedent's Name (First, Middle, Last)     WILLIAM SISLER	EVANS			Ī			2. Dete of De Month Septe:	Day mber 14	Year 2000	3. Time of Death  2:35 am
kaminer	4a Facility Name (If not institution, give street and nu Stella Maris	mber)				o. City, Tov Cimon:		cation of Deat		of Death	
neral	5. Social Security Number 6. Sex 120-10-5642	7. Age (In yrs. las	st birthdey)	If Under 1 Y Months D	1	If Under 2 Hours		8. Dete of Bir (Month, Da June 2			ace (State or Foreigny)
ector	Usual Residence of Decedent	92				1		June 2	3, 1908		Md.
14	10a. Siele 10b. County	10c. City,	Town or Loca	alion						10	d. Inside City Limit
at be notified at al Director	Md. Baltimore		Timoni	um							1 ☐ Yes 2 🖾 No
ner must be notified uneral Director	10e. Street and Number			10f. Zip Co					10g. Citizen of 1		ry?
a la	2300 Dulaney Valley Rd.				093					SA	
by Funeral	11. Meritel Stetus  1 Never Merried 2 Merried  1 Yes fif Yes, Gi Yeer or I	2 1 No		es Decedent Yes, specify  Yes 2  W		Specify:	in? (Spe , Puerto F	cify Yes or No Rican, etc.)	Black Specify	e - America ck, White, e	tc.
	15. Decedent's Education		16a. Decede	nt's Usual O	ccupat	ition			16b. Kind of B		
Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (	1-4or 5+)	16a. Decede (Give ki life. Do	ind of work d O NOT use re	one du etired)	uring most	of workir	ng			
Com	12		Office	Manag	er				William	G. S	carlette
o Be	17. Father's Name (First, Middle, Last) George Washington	Evans				18. Mother			, Maiden Sumen	Cul	n
lury or other trauman	19a. Informent's Neme/Reletionship (Type, Print)	Dvans	19b. Meiling	Address (Si	reet at				er, City or Town,		4
	Mr. James S. Evans/son							, Md. 2			
	20e. Method of Disposition	Con	ce of Disposi	ition (Neme o	of			Dete	20c. Location	City or Tov	vn, State
	1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from 4 ☐ Donetion 5 ☐ Other (Specify)	State	ney Va				19	/18/00	Timoni	um. M	d.
	21. Signiffmen of European Sprace Internate	) ,	22 R	Neme and A UCK TO	ddress	s of Facility	nera.	1 Home,	Inc.	,	
	23a. Part1. Enter the diseese, or complications that a shock, or heart failure. List only one cause on a	aused the deeth.								1	Approximata Intervel Between
VMedical Examiner	Due to (or as a consequence of):    Due to (or as a consequence of):										
Physician	d										
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ă Ö	25. Was case referred to medical	261611			-	26 Dinos	of Death	(Check only			1 1 45 Z L NO
98 0	axaminer?	Inpatient 2 El	R/Outpatient	3 DOA	Othe				denca 6 □Ott	er (Specify	)
÷ 0		8b. Time of Injury		Injury Work		2		how injury occur			
	27. Manner of Death			141	101						
	Neturel 5 Pending (Mon 2 Accident 3 Suicide 6 Could not be determined 28. Place	a of Injury - At homing, etc. (Specify)	e, ferm, stree				2	28f. Location ( City or To	Street and Numi wn, State)	ber or Rural	Route Number,
	Variety   Sample   Pending investigation	a of Injury - At homing, etc. (Specify)	edge, deeth (	et, fectory, of	fica	e, date end	d placa, e	City or To	wn, State) cause(s) and m	annar as st	ated.
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	Variety   Cartifying Physician: To the Check only one)   Could not be determined	a of Injury - At homing, etc. (Specify)  best of my knowle asis of examination	edge, deeth (	occurred at the stigation, in 29c. Li	ne time my opi	e, date end inion, deal	d placa, e	City or To	wn, State) cause(s) and m date and place,	annar as sta and due to and (Month, L	ated. the cause(s)
pletely filled in by the funeral edical Certification:	Continue   Continue   Continue	a of injury - At homing, etc. (Specify)  best of my knowle asis of examination ner stated.	edge, deeth on and/or inve	et, fectory, of occurred at the stigation, in 29c. Li	fica ne time my opi cense	e, date endinion, deal	d placa, e	City or To	cause(s) and m date and place,	annar as stand due to	ated. the cause(s)

Registrar

NAME: EVANS, WILLIAM



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Domenic John Ecalono 4:40AM September 10 2000 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel belain If Under 24 Hrs. 8. C If Under 1 Yeer 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 84 079-16-1539 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 No Director MD Harford Bel Air 10a. Street and Number 10f Zin Code 10g. Citizen of What Country? U.S.A. 951 L Pentwood Road 21014 Funeral 12. Was Decedent Ever in U,S.
Argued Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. WWII 1 Never Married 2 Merried Specify: White 1 Yes 2 No Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 General Manager Automotive 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Charles Joseph Ecolono Rose Reda 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 951 L Pentwood Road, Bel Air, Maryland 21014 Dawn Ecalono (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/14/00 Woodlawn, Maryland Woodlawn Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Loring Byers Funeral Directors, Inc 8728 Liberty Road, Randallstown, Maryland 21133 ellner the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, earl failure. List only one cause on each line. Approximate Interval Between Onset and Death Pneumonia Immediate Cause (Final day disease or condition resulting in deeth) Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Par Kinsons DISTUSA 1 Yes 2 No 3 Probably 4 Unknown Aq 24b. Were autopsy findings available prior to Completed Demontin 24a. Wes an autopsy performed? completion of cause of death? 200 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical axaminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 D Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

To the Hospital within 24 hours a To the Funerel D completely filled

after deat Director:

State Registrar

DHMH 16 Rev 6/95

**Funeral** 

Director

r than "natural", or items 23a or 28s-f show the Medical Examiner must be notified at

72 hours after

Hygiene.

permit. Pages 1 and 2 should be filed wil Department of Health and Martal Hygiera Important: If fem 27 is marked other tha any filury or other traumatic event, ma. PADS.

**Physician** 

/Medical

Examiner

signed by t

Baitimore, Maryland 21215-0020

31. Dete filed (Month, Day, Year) SEP 1 5 2000

HIW18

29b. Signature and title of certifier

Scott

32. Registrar's Signature

2 North

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bel Air Muny lund

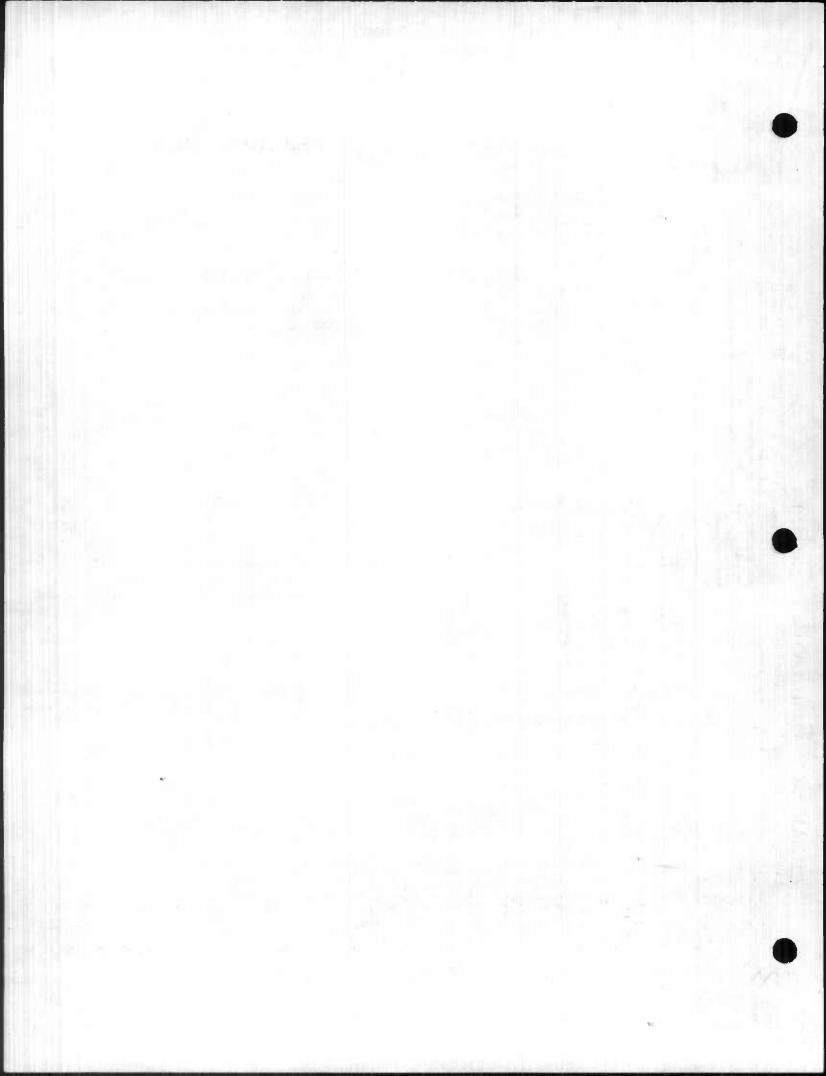
29c. License number

29d. Dete signed (Month, Day, Year)

Siptimber 10, 2000

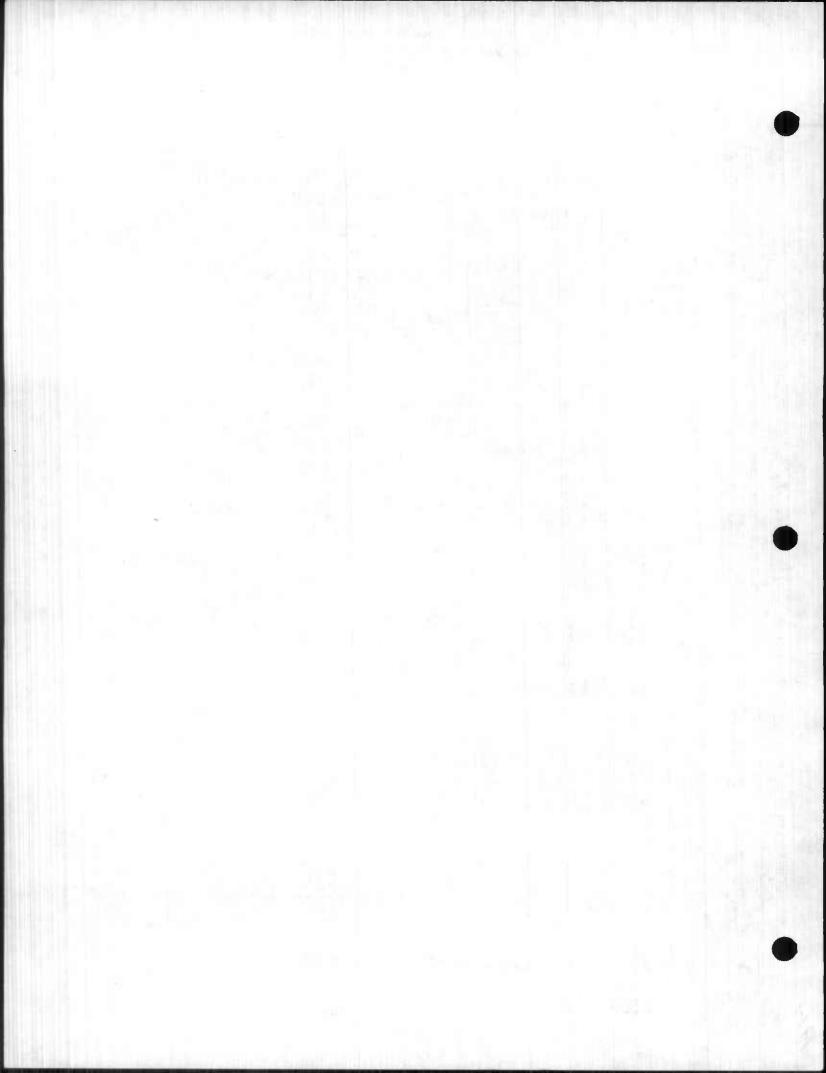
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State of Maryland / Department of Health and Mental Hygiene 0 0 29208

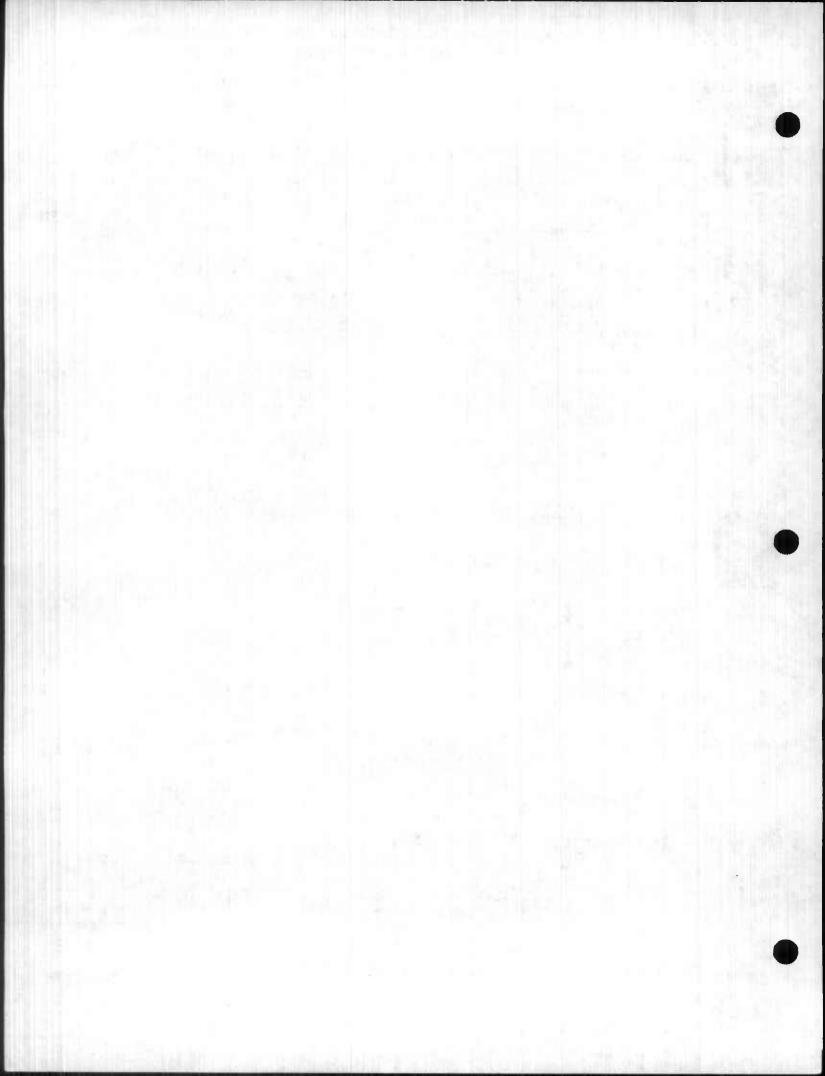
			Certifica	te of Death	Reg. N	lo.	
			1. Decedent's Name (First, Middle, Last)		2. Date of Death Month D	ay Year	3. Time of Death
	Physic	_	Cory D. Figueroa		September		2059 pm
	/Medi Examii	_	4e Facility Neme (If not institution, give street and number)	4b. City, Town, or L	ocation of Death	c. County of Deeth	
	- LAUITIII		Shock Trauma	Baltimor	re I	N/A	
-	Funeral			er 1 Year   If Under 24 Hrs.	8. Dete of Birth (Month, Day, Yea		lece (State or Foreign
	Funeral Director		212-96-4608 12(M 20 F 20) Yrs. Months	Deys Hours Min.	A (Month, Day, Yea	980 Main	Puland
_	_		Usual Residence of Decedent		riag. S/I	100 11 19	9141100
	show		10a. Stete 10b. County 10c. City, Town or Location			1	0d. fnslde City Limits
	the Maryle 28a-f shor	ō	Maryland NIA Baltin	mare			1 Yes 2□No
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	th with	□	1674 David Hill Avo	2/2/7	Diego Tit	115A	
	eath m 2	Funeral Director	11. Marital Stetus 12. Was Decedent Ever in U.S. 13. Was Dec	edent of Hispanic Origin? (Sp	pecify Yes or No-	14. Rece - Americ	an Indien,
	her dea	2	Armed Forces? If Yes, sp	ecify Cuben, Mexican, Puerto	Rican, etc.)	Bleck, White,	etc.
320	T's af	by	3 ☐ Widowed 4 ☐ Divorced Yeer or Dates:	20 No Specify:		Specify:	act
21215-0020	be filed within 72 hours after death with the Maryland lal Hyglene.  d other than "natural", or flems 23a or 28a-f show avent, the Medical Examinet must be notified at	8	15. Decedent's Education 18e, Decedent's Us	ual Occupetion	16b.	Kind of Business/Inc	dustry
15	in 72	Be Completed	(Specify only highest grade completed) (Give kind of w	rork done during most of work	ring	) /	0
212	The state of	E O	Elementary/Secondary (0-12) College (1-4or 5+)	ry Wark	er /	civate	(6)
D	filed Hard	Ö	17. Father's Neme (First, Middle, Last)	18. Mother's Nem	e (First, Middle, Maide	en Sumeme)	
an	d be sold be compared by the c	B	Maurico Rako.	Mick	2010	FIGURE	$\Gamma \cap \alpha$
Maryiand	d 2 should be filed within and Mental Hygiene. 7 Is marked other than traumatic avant, the H	2	19a. Informent's Neme/Relationship (Type, Print) (9 Cand father 19b. Mailing Addre	ss (Street and Number or Ru	ral Route Number City	or Town, State, Zin	Code)
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e î	s 1 end 2 f Health Itam 27 i		20a Method of Disposition (N	eme of	/Date/ 20c.	Location - City or To	Wn. Stete
Baltimore,	Peges nert of mt: If its rry or o		1 Burial 2 Cremation 3 Removal from State	other place)	1/18/2011	- /	111
tim	tmer tamt		4 □ Donation 5 □ Other (Specify) V T, ∠ ( )	n	1-12000 La	nsaow	ne, Ma.
39	permit. Peg Department Important: If any Injury o			and Address of Fe	Filmo	val Ha	MAR
ш	20519		March Like 300Se	Physical	AVO B	TE Ma	21216
- 12			23a. Part Lenter the distriction of the complications that caused the death. Do not enter the methods, or heart tallers. Let only one ceuse on each line.	ode of dying, such as cardiac	or respiratory errest,		Approximate Interval Between
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4	/Medical		Immediate Ceuse (Final disease or condition	Gunsh	ot W	ounds	
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	the death certificate be executed y the attending physician and iched for use as the bunal-transit	edical Examiner	Sequentially list conditions.  Due to (or es a consequence of	):		1	
ó	an ar	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury				
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68	g phys	8	resulting In death) Last				
X	nding use as	2	d			-	
m	seath ce attend d for us	2	Dat II. Other shealthand and lifere and lifere and lifere and life to death but not reculting in the underlying	anusa siusa in Bart I	22h Did tohoo	to use contribute to	the cause of death?
0		Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Pen I.			bably 4 Unknown
0	es that igned b				1 Yes	2E NO 30 PIO	babiy 4 Dinknown
Records,		Completed by			24e. Wes en au		era autopsy findings
Ö	been s	ete			performed	av co	ailable prior to mpletion of cause
36	N S S	du				of	deeth?
	The state of	S			1 TYes	2 No 1	Yes 2 No
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of	this c	2	1 X Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 I		ome 5 Residence		y)
2		ë	27. Menner of Death  1 Natural 5 Pending  28a Date of Injury  28b. Time of Injury	28c. Injury et Work?	28d. Describe how in	jury occurred	1 +
Division	Attending or death. ector: Afte by the fune	ati	2 Accident investigation 9/12/00 2025 M	1 ☐ Yes 2 ☑ No	Subje	et o	nol
× ×		ti	3 ☐ Suicide  Could not be determined  286. Plecs of Injury - At home, farm, street, factor building, etc. (Specify)	ory, office	281. Location (Street City or Town, Ste	and Number of Run	Route Number
	a after or in be	Certification:	Street (Found)		Balton	27 C. M	cyland
	To the Hospital within 24 hours a To the Funeral I completely filled	Cal	29a. Certifier  Check only  Madical Examiner: On the basis of examination and/or investigation				
	n 24 n 24 n Fi	edical	(Check only one)  2 Medical Examiner: On the basis of examinetion and/or investigation and menner steted.	л, и ту ортноп, деет осси	100 at trie time, 0010 8	and place, and due to	Jule Ceuse(s)
	To the Hospital within 24 hours a To the Funeral I completely filled	Ž	29b. Signature and title of pertifier	9c. License number	29d. [	Date signed (Month,	Dey, Year)
			Letterer (1.1)	O.C.M.E.	Sex	otember 13	3, 2000
	0	-	30. Name and as fress of person who completed cause of death (Item 23a) (Type, Print)		E		
				Street, Balti	imore, Mary	land 2120	)1
	Šta	te	31. Date and (Month Day, Year) 32. Registrar's Signeture	/			
	SIG Pagisti		SEP 1 5 2000 Server 19 As	outs			



State of Maryland / Department of Health and Mental Hygiene 10 29219

	Certificate of Deat	h Reg. No.	200		
<b>D</b>	Decedent's Neme (First, Middle, Last)	2. Data of Death Month Day Year	Time of Death		
Physician /Medical	Frances C. Flaherty	Sept. 11, 2000 /3	1:00 PN		
Examiner	4a Fscility Name (If not institution, give street and number) 4b. City,	Town, or Location of Death 4c. County of Death			
	911 Stormont Circle Arbu				
Funeral Director	215-40-6727 1 M 2QXF 57 Yrs. Months Days Hours	er 24 Hrs. S. Data of Birth (Month, Day, Year) Jan. 27, 1943  9. Birthplace (Country) Mary La	State or Forei		
2	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d In	side City Limi		
sho St			□ Yes 2 🗖 N		
or 28e-f show be notified at Director	MD Baltimore Arbutus  10e. Street and Number 10f. Zip Code	10g Citizen of What Country?	10g. Citizen of Whet Country?		
0 2 0	911 Stormont Circle 21227	U.S.A.			
L', or he by Fu	3 ☐ Widowed 4 ☐ Divorced Year or Dates:				
"netural".	15. Decedent's Education (Specify only highest grade complated)  16a. Decedent's Usual Occupation (Give kind of work done during m	ost of working			
- 2	(Specify only highest grade completed)  (Give kind of work done during m life. DO NOT use refired)  10  (Give kind of work done during m life. DO NOT use refired)  Homemaker	Own Home			
Be C		ther's Neme (First, Middle, Maiden Sumame)			
Mental Me	Albert C. Brechbiel G	race M. Baker			
th and M	19a. Informent's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Num	nber or Rural Route Number, City or Town, State, Zip Code rcle Arbutus, MD. 21227	)		
point. Tages than 2 should be itself white Department of Health and Mental Hygiere. Important: if item 27 is marked other than any injury or other trsumatic svent, the Monce.  To Be Comp	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from Stete 4 Donation 5 Other (Specify)	Date 20c. Location - City or Town, S Catonsville,			
	21. Signature of Funeral Service Licensee  Ambrose Funer	al Home, Inc.			
/	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart lailure. List only one cause on each line.	Spring Rd. Arbutus, MD. 212	227 oximate		
ing physician and as the burial-transit	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
gned by the attending be detached for use s by Physician/M	Part II. Other eignificant conditions contributing to death but not rasulting in the underlying causa givan in Pa	rt I. 23b. Did tobacco use contribute to the	23b. Did tobacco use contribute to the cause of deat		
gned by be detac by Ph		1 2 No 3 Probably	4 🗆 Unkn		
should should		24a. Was an autopsy performed?  24b. Wera au available complet of death	itopsy finding prior to ion of cause ?		
page ha	Maria Company of the	1 Yes 2 No 1 Yes	2□ No		
s certificate has director, page 2	25. Was case reterred to medicat 26 Pt	aca of Deeth (Check only one)			
this certific ral director, TO Be	axaminer? Hospital: Other:	Nursing Home Residenca 6 □Other (Specify)	7,45		
within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director. After this Medical Certification: To	27. Manner of Death  1. Naturat 2 Accident   28a. Date of Injury   28b. Time of Injury   28c. Injury et Work?  2 Accident   Accident	28d. Describe how injury occurred			
Direct d in by	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Rou City or Town, State)	ita Number,		
within 24 hours after To the Funeral Dir completely filled in	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and manner stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and manner stated.	and piaca, and due to the cause(s) and manner as stated. leath occurred at the time, date and piaca, end due to the c	cause(s)		
Within Comple	29b. Signature and title of certifier 29c. Licansa number				
,	WELL MD D505	17 9/13/00			
10	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	17 9/13/00 MD 21228 Dr. Le	vickes		
State	31. Data filed (Month, Day, Year)  32. Registrar's Signature  Aparks				

**ORIGINAL** 



State of Maryland / Department of Health and Mental Hygiene

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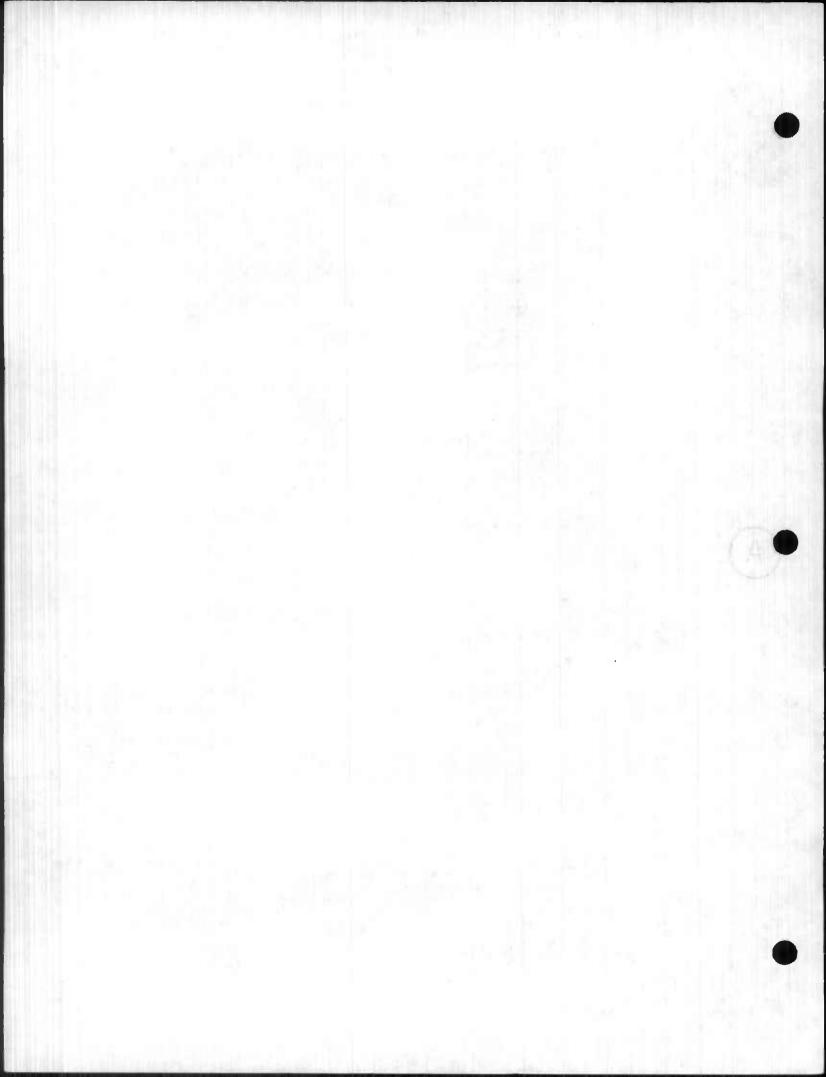
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U	U	2	9	2	1	(

P Amended	Item#28c,28f perPHYG787 9/1	15/2000 EW	Certificate of	Death	Reg	. No.	27210
	Decedent's Nama (First, Middla, Last)				2. Data of Death Month	Day Year	3. Time of Death
Physician /Medical	Vincent	J.	Fr	ate	SEPTEMBE		1508
Examiner	4a Facility Nama (# not institution, giva street	and number)		4b. City, Town, or L	ocation of Death	4c. County of Death	
	BAYVIEW HOSPITAL		The Real Property of	BALTIMOR		N/A	
Funeral Director	5. Social Security Number 6. Sex 174 174 175	7. Aga (In yrs. last	birthday) If Undar 1 Yaa Months Day	Hours Min.	(Month, Day, Y	9. Birth Cou 1,1962 I	pplaca (State or Foraign untry) Md .
	Usual Rasidence of Decedent  10e. Stata 10b. County	100 City T	own or Location				10d. Inside City Limits
there 23e or 28e-1 show ner must be notified at uneral Director		Toc. City, 1	OWN OF LOCATION				1 Yas 2 No
or 28a-f s be notified Director	Md Baltimore	Dun	dalk		140	07777	
D 20	10e. Streef and Number		10f. Zip Code		W	. Citizen of What Cou	untry /
ara lex	7814 Scholar Road	- B	21222	High ale Origina /Sa	US	14. Race - Amar	ican Indian
by F	1 Nevar Married 2 Married 1 H	/as Decedent Evar in U,S. med Forcas? □ Yas 27 No Yas, Giva aar or Datas:	13. Was Decedant of	Hispanic Origin? (Sp ban, Maxican, Puarto o Specify:	ecity tas of No- Rican, atc.)	Black, White	
B	15. Decedent's Education	1	6e. Decedent's Usual Occ	upation	16	b. Kind of Business/I	ndustry
Completed	(Specify only highast grada com Elementary/Secondary (0-12) C	ollege (1-4or 5+)	(Giva kind of work don lifa. DO NOT usa ratio	a dunng most of work red)	ang		
EO.	12 yrs		Loader		Ir	nter Rai	1
Bec	17. Fathar's Nama (First, Middla, Last)		17-17-17-1	18. Mother's Nam	a (First, Middle, Me	idan Sumeme)	
0	Vincent A. Frate			Bernadi	ne Koslo	osky	
-	19a. Informent's Neme/Reletionship (Type, P	rint)	19b. Mailing Addrass (Stra	at and Number or Rui	ral Route Number, C	City or Town, Steta, Z	ip Code)
	Vincent A. Frate	Father	7814 Schol	ar Road,	Dundal	c, Md.21	222
	20a. Mathod of Disposition  1  Burial 2 Cramation 3 Ramov 4 Donation 5 Other (Specify)	cem	a of Disposition (Nama of atery, cremetory or other p red Heart	of Jesus	ept 7	c. Location - City or I	
	21. Signature of Funaral Sarvice Licensee		22. Nama and Add		2000 Di	illuaik,	Mu
	23a. Party Enter the distance for complication shock, or heart failure. Lat only one car	ns that ceused tha daati use on aach lina.	Connelly 7110 Sol Do not enter tha moda of d	lers Poi	nt Rd. I	hindalk.	Md. 212: Approximata Interval Batween Onsat and Death
nn ial er	Immediata Causa (Final disease or condition rasulting in death)		Mustic d	Morica	استرسن	1	
Examiner	b					i	
Xar	Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disease or injury c	Dua to (or as	s a consequance of):				
ai	cause. Enter Underlying Cause (Disease or injury that initiated avants						
ician/Medicai Examin	resulting in death) Last	Dua to (or as	a consequence of):				
Σ	d						
- lan							
Physician/	Part II. Other significant conditions contribut	ing to death but not rasulting	ng In tha undarlying ceusa	given in Part I.	23b. Did tobi	1/	to the caues of death
					1 Yee	2 2 4 16 3 □ Pr	obably 4 Unknow
dby					24a. Was an	autoney 24b. 1	Ware autopsy findings
Completed					performe	d?	available prior to completion of ceuse
npl					. /		of death?
S					Yas	2 No	I □ Yas 2 □ No
Be	25. Was casa rafarred to medicel axaminar?			26. Placa of Dea	th (Check only ona)		
10	1⊠ Yas 2□ No Hospit	al: 1 ☐ Inpatient 2 ☐ EF	VOutpatient 3♥ DOA	Othar: 4 ☐ Nursing H	oma 5 Residen	ca 6 Othar (Spec	city)
		a. Data of Injury (Month, Day Year) 28	Bb. Tima of 28c. In Injury	jury at	28d. Dascribe how	injury occurred	
atio	1 Neturel 5 Pending 2 Accidant investigation	VMC	Injury M	☐ Yas 2 No	USED	mucis.	
Certification:	3 ☐ Suicida 6 ☐ Could not be 28	a. Place of Injury - At home	a, farm, straat, factory, offic	0	28f. Location (Stre	et end Number or Ru	ıral Routa Number,
er	4 Homicide	building, etc. (Specity)	CNA		City or Town, UNKNO		
edicai C	(Check only 27 Medical Examiner: C	: To the best of my knowle	dga, death occurred et the	time, date and piece, opinion, daath occur	and due to the cau	se(s) and manner as	stated. to the cause(s)
Medical Certif	29b. Signature and fitta of certifiar	4	29c. Lica	nsa number	290	d. Data signed (Monti	h, Dey. Year)
	V DUM TO CO	( lin 10	1.1.	.M.E		EPTEMBER O	
	Long- Alve	Julie			51		-,-000
	30. Nama and addrass of person who comple	ed ceusa of deeth (Item 2:				fo. N	
	MISINGSTUS	7. KOKETU	111 Pe	nn Street,	Baltimor	re, Maryla	nd 21201
×	31. Data filed (Month, Day, Year)	32. Registrar's Signatur	9				

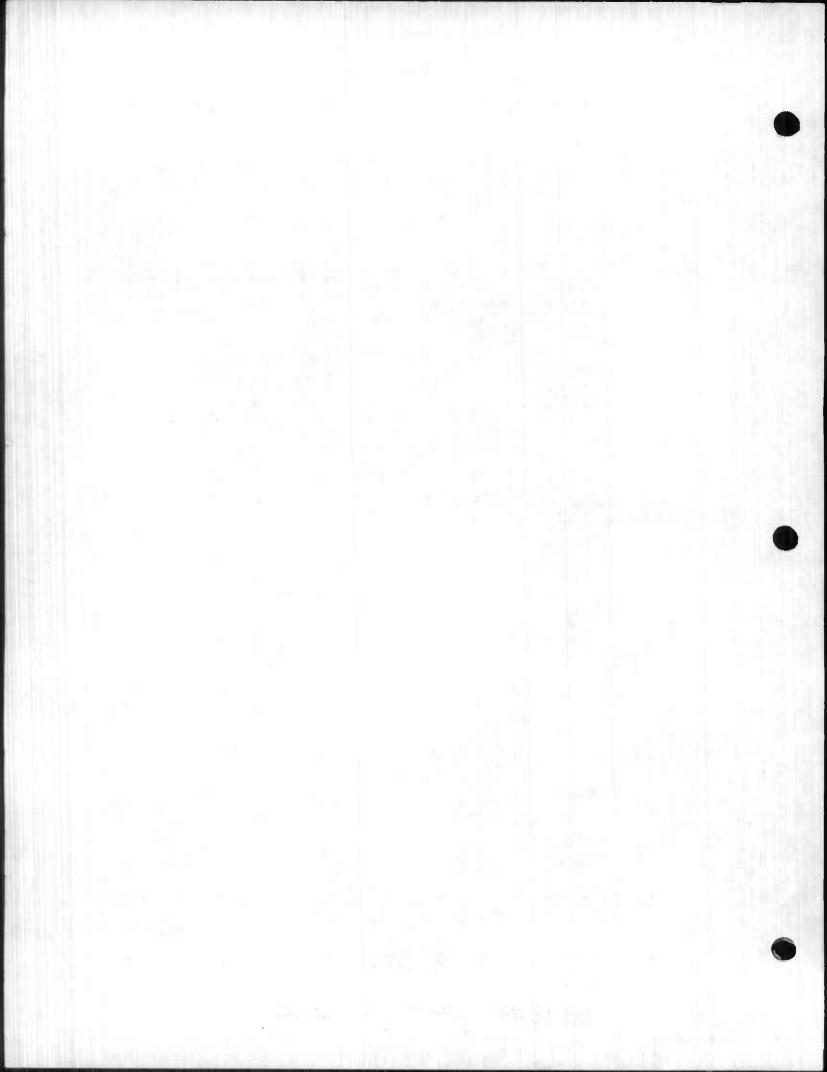
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MUEL GAINES amend item	State of Maryland / Department of Health and Me 23a, ptII, 27 per me G787 9/25/00 yf Certificate of Death	ental Hygiene Reg. No.	00 29211
Physician /Medical		2. Dete of Death Month Dey SEPTEMBER 12	3. Time of Deeth 2, 2000 22:22 PM
Examiner  Funeral Director	214-44-8310 PM 231 33 Yrs.		ounty of Deeth TIMORE  9. Birthplece (State or Foreign Country) MD
ahow a m	Usuel Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location BALTIMORE		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
death with the Maryland ms 23s or 28s-f show crease be notified at neral Director	10e. Sireef and Number 10f. Zip Code 1906 FEATHERBED LANE 21207		on of Whet Country?
020 urs after alf, or its	11. Merital Stetus  12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. If Yes, specify Cuben, Mexican, Puerto R		. Rece - American Indian, Black, White, etc. pecify: BLACK
12 를 열	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondery (0-12) 12th 15. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ELECTRICIAN	g 16b. Kind	of Business/Industry  AIT ELECTRIC CO
Maryland 212 d 2 should be filed within and Medical Hygiene. The and Medical Hygiene. Transted coverty trees. To Be Comp	17. Father's Name (First, Middle, Last)  WILLIAM C. GAINES  18. Mother's Name  MARY LUI	(First, Middle, Maiden St MPKIN	umame)
re, Maryland 21 s 1 and 2 should be filed wir health and Montal Hygien fam 27 is marked other that other traumatic event, the	19e. Informent's Neme/Reletionship (Type, Print)  SYLVIA GAINES — WIFE  19b. Meiling Address (Street and Number or Rural 1906 FEATHERBED LANI		
Pege nent o int: If I	20e. Method of Disposition  1 Burial 2 Cremetion 3 Removel from State CARRISON FOREST VETERANS  9-		ntion - City or Town, Stete
Baltimo permit. Peg Department Important: H any Injury o	21. Schmum of Funerel Service Licensee  Markenend Adding Raily Hon 4300 WABASH AVE.		INC. ID 21215
The law requires that the death certificate be executed the law requires that the death certificate be executed ate has been signed by the attending physician end page 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)  Due to (or as e consequence of):  Due to (or es e consequence of):  b.  Due to (or es e consequence of):  Due to (or es e consequence of):  c.  Due to (or es e consequence of):  Due to (or es e consequence of):		
P.O. Box 6 that the death certification of detached for use est of Physician/Me	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert f.	23b. Did tobacco u	se contribute to the cause of death?
ds, P.O. ires that the dispendent by described by the dispendent by the dispendent by the dispendent by Phys	ALCOHOLISM	1   Yes 2	No 3⊠ Probably 4 Unknown
Vital Records, P.O. Box ( lician: The law requires that the death certificate has been signed by the attending rector, page 2 should be detached for use e  Be Completed by Physician/M.		24a. Wes en eutops: parlormed?	24b. Were autopsy tindings available prior to completion of cause of death?
	25. Wes case referred to medical 26. Place of Deeth	121 Yes 2 [	No 1 ☑ Yes 2 ☐ No
Division of V or Attanding Physic after death. Under this co in by the funeral dire ertification: To ertification: To	examiner?    No   Hospitel:     I   Inpatient   2   ER/Outpatient   3   DOA   Other:   4   Nursing Hom	ne 5 Residence 8. 8d. Describe how injury	Number or Rural Route Number,
To the Hospital within 24 hours to the Funeral completely filled Medical Co	29e. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, et control of examinetion end/or investigation, in my opinion, deeth occurre end menner steled.		
To the within To the comple	29b. Signeture end fille of certifier  29c. License number  29c. License number  0.C.M.E.  30. Neme end address of person who completed cause of death (turn 23a) (Typa. Print)		signed (Month, Day, Year) MBER 13, 2000
State Registrar	Stephen S. Radentz 111 Penn Street, Bal:  31. Date filed (Month, Day, Year)  SEP 15 2000 Server B. Spain	timore, Mar	yland 21201



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. 10e, 10f, perFH, G787, 9/15/00dhb Department of Health and Mental Hygiene Certificate of Death AMEND ITEM: #25 PER PHY G789 9-15-00 WR 2. Data of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Deeth Day LYNU DENISE GASQUE Suprombon 12:30 Am 10 2000 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, give street and number) 4c. County of Death SINAL BALTIMOKE BALTIMORO HOSPITAL OF If Undar 1 Yaar If Under 24 Hrs. 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex Months Deys Hours Min 1 M 2 F 213-76-6707 Usual Residence of Decedent Yrs. June 13, 1959 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 Dyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 N. Belnord Avenue 21205 2 12. Was Decedent Evar in Armed Forcas?

1 Yes 2 No If Yes, Give Yaar or Datas: Was Decadant of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, nue, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decadent's Usual Occupation
(Give kind of work done during most of working life. PO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Rural Route Number, City mant's Name/Relationship (Type, Print) Mother 19b. Mailing Address (Street end Number or 2050 Place of Disposition (Name of cemetery, crerpatory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 Cramation 3 Removal from Stata 4 □ Donation 5 □ Other (Specify) 21. Signature of Funaral Service Licensee 233 Part 1. Enter the disease, or complications that caused the daath. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or haart fallura. List only one cause on each line. Approximate Interval Between Onsat and Death Immediate Causa (Final disease or condition resulting in death) PNEUNODIA 4 DHYS Due to (or as a consequence of): AIDS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events rasulting in death) Last Due to (or as a consequence of): CARDIOMYOPATHY Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 No 3 | Probably 4 | Unknown DRUG-INDUCED HEPATITIS 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yas 20 No 25. Was case referred to medical axaminar? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1 Yes 25 N Other: 4☐ Nursing Home 5☐ Residenca 8 ☐ Other (Specify) 27. Manner of Death 1 Natural 28b. Tima of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident

Examiner The law requires that the death certificate be execu as the burial-tra Box P.0. Division of Vitai Records. this certificate hes I or Attending Physician: after death.

Director: After this certific d in by the funeral director, yd ni bellil Physician/Medical Examiner

Be Completed by

Medical Certification: To

3 Suicide

29a. Certifier

4 Homicide

29b. Signatura and titla of certifie

**Physician** 

/Medical

Examiner

Director

or items 23s or 28s-1 show

Funeral Director

by

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To Be

traumatic event, the Madical Examinar must be notified at

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eny injury

**Physician** 

/Medical

Pages 1 and 2 s ment of Health an permit. Pages 1 and 2 Department of Health a Important: If item 27 is

the Maryland

filed within 72 hours after

Maryland 21215-0020

Baitimore,

To the Hospital within 24 hours a To the Funeral Completely filled

State Registrar

DHMH 16 Rev 6/95

FRED SULLINGS, MD 31. Data filed (Month, Dey, Year)

6 Could not be determined

2401 32. Registrar's Signatura repera

BELLEDERF HUE West

1 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licansa number

056660

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

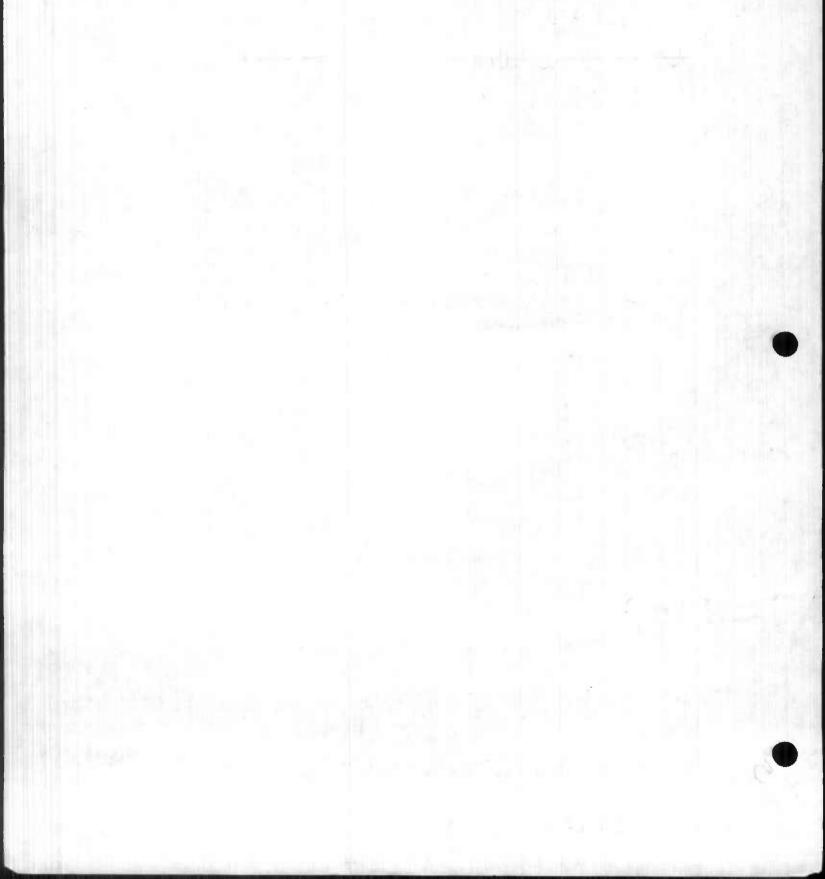
BATIMORO, ND 21215

STPTEMBOR 10, 2000

2000

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



	Physician
	/Medical
4	Examiner

8 238 à

z Mental . tant: If item 27 Pages

Maryland 21215-0020

Baltimore,

Box 68760,

Division of Vital Records.

**Physician** /Medical Examiner

The law requires that the death certificate be execu this certificate has been signeral director, page 2 should be Hospital or Attending Physician: 24 hours after death.
 Funeral Director: After this certifical stely filled in by the funeral director, g Certification: To Medical

1. Decedent's Name (First, Middle, Last) 3. Time of Death Francis Joseph 11/2/2 4b. City, Town, or Location of Deeth 4a Facility Name (If not Institution, give street end number) 4c. County of Death Wonths Deys House 24 Hrs. 8 Date of British HOS KINS 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Months 1X M 2□ F 71 579-36-1320 Yrs. Washington, D.C. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 ☐No Director Jefferson Charlestown 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 25414 28 Turnberry Drive USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White py 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manufacturers' Representative Contract Furniture 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) John Glotzbach Mary Kaltenbach 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 28 Turnberry Drive, Charlestown, WV 25414 Irene P. Glotzbach/Wife 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremetion 3 ☐ Removal from State Metro Crematory, Inc. 9/7/00 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. Green Chik Edward A. 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) 36 hours Sepsis Due to (or as a consequence of) 48 hours Physician/Medical Examiner Aspiration PNEUMONIA Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or as a consequence of) Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ntraabdominal abscess Be Completed by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28d. Describe how injury occurred 28c. injury at Work?

\*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

5 Pending

investigation 6 Could not be

1 Natural 2 Accident

3 ☐ Suicide

29a. Cartifier

4 Homicide

29c. License number

29d. Date signed (Month, Day, Year)

281. Location (Street and Number or Rural Route Number, City or Town, Stete)

RES-000

1 Yes 2 No

September 6, 2000

30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)
Geoffrey C. Nguyan, M.D., 600 North Wolfe Street, Baltimore, MD 21287

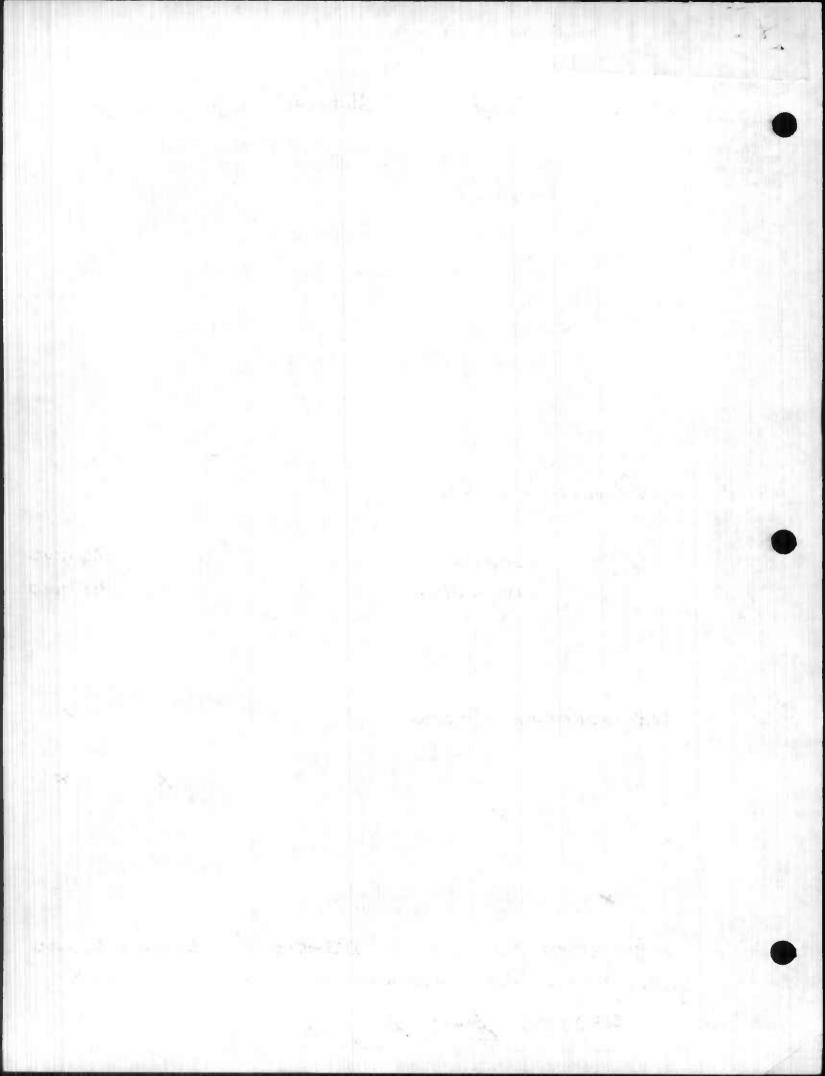


28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

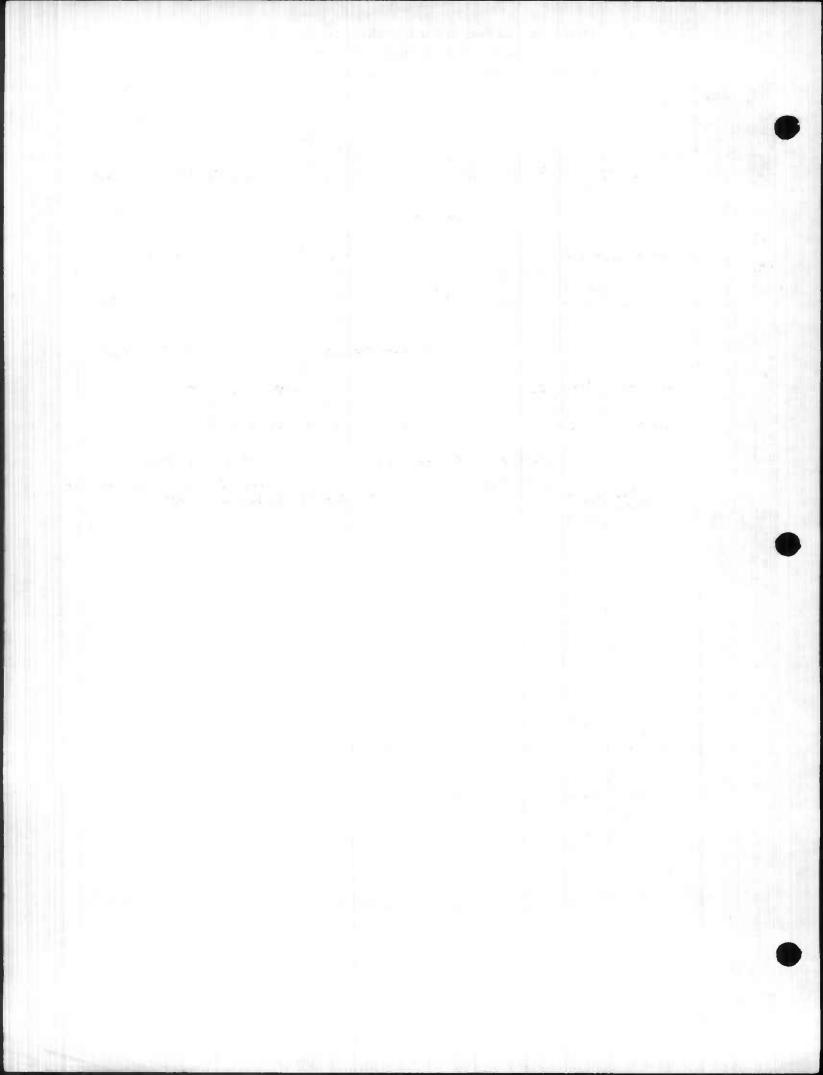
**ORIGINAL** 

**DHMH 16 Rev 6/95** 

State Registrar

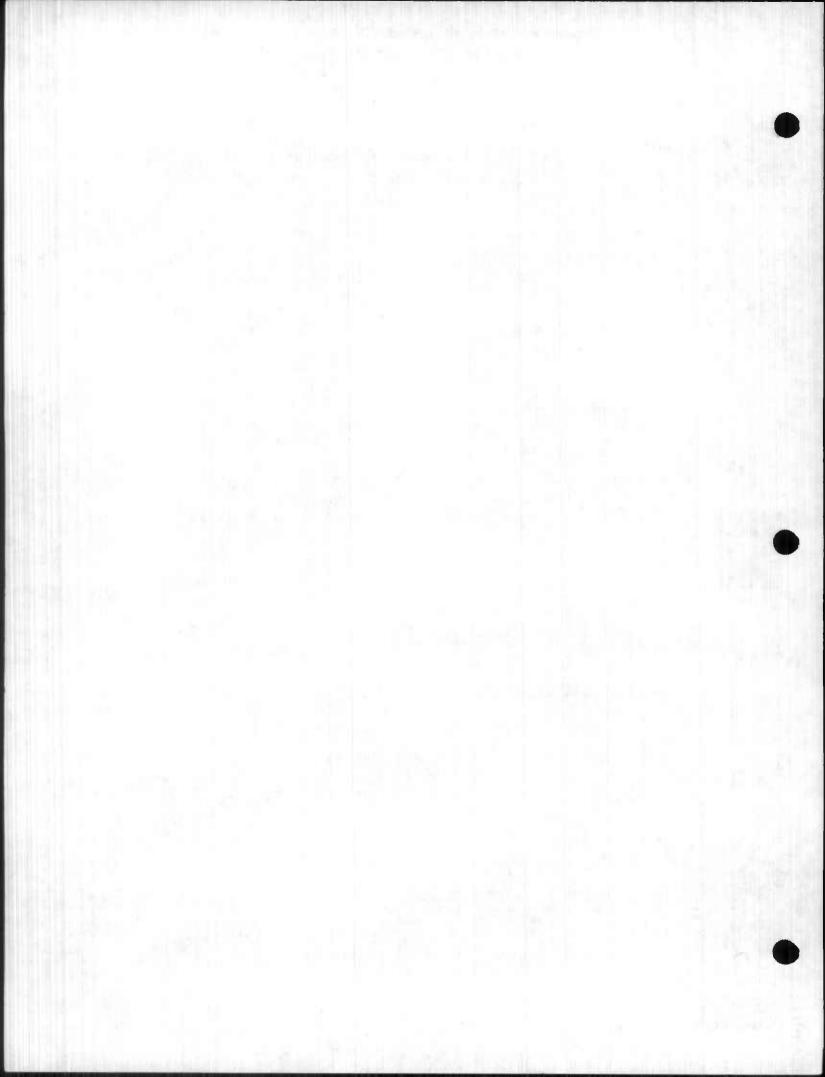


veicion	nded Item#29c perP	ddle, Last)		Ce	rtificate c	Deall		2. Date of De Month	Reg. No.	Year	3. Time of Death
ysician Medical	FREDERICH 4a. Facility Name (If not institu	`	ROSS			4h City Toy			BER 13	2.000	1:15 A
aminer	GOOD SAMARITA					BALT				T/MC	RE
eral ctor	5. Social Security Number 215-16-0902	6. Sex 1 M 2 □		s. last birthday) Yrs.	If Under 1 Ya Months Da		Min.	B. Date of Bir (Month, De uly 27,	th by, Year) 1919		ace (Stata or Foraig ry) ore, MD
11	Usual Residence of Decedent 10a. State 10b. Cou	nty	10c. C	City, Town or Lo	ocation						d. Inside City Limit
rector	MD		Ba	ltimore							1 Yes 2 N
Director	10e. Street and Number				10f. Zip Cod	0			10g. Citizan of	What Count	ry?
	5404 Hillburn Av				21214				U.S.A.		
by Funeral	11. Marital Status  1 Never Marriad 2 N N 3 Widowed 4 Divorce	Arme	Decedant Evar in od Forces?  Yes 2 No WW or Datas:	TT	Was Decedant of Yes, specify C	uban, Mexican,	gin? (Spec , Puarto Ri	ity Yes or No ican, atc.)		ce - America ck, White, a	itc.
	15. Deced	lent's Education		16a. Dece	dent's Usual Oc	cupation	a fi semalela	_	16b. Kind of B		
Completed	Elementary/Secondary (0-12	hest grade comple 2) Colle	ge (1-4or 5+)		kind of work do DO NOT use re		or working	9			
	17. Father's Name (First, Midd			Engine	er/Desigr	1	r's Name /	First Middle	B & O Ra		
To Be	Frederick G. Gro					Marga		L. Kii		14)	
-	19a. Informant's Name/Relation	onship (Type, Print)	)	19b. Maili	ng Addrass (Str				er, City or Town,	Stete, Zip	Code)
	Willabelle K. Gro	ss- Wife			lillburn A		altimo	re, MD	21214		
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematic	n 3 🗆 Removal f		Placa of Dispo cemetery, crar	sition (Nema of metory or other	oleca)		Date	20c. Location -	City or Tov	vn, State
	4 ☐ Donation 5 K Other	(Specify) ntont	oment.   Gar	dens of				16/00	Baltimore	e, MD	
Sono	21. Signature of Funeral Servi	Ce Licensee Will	liam G. Dau		2. Name and Ad 305 Harfo		Leona		uck Funera 21214	al Home	e, Inc.
an al	23a. Part1. Enter the disease shock, or heart failure. L	or complications to list only one causa	hat ceused tha dea on each line.		er the moda of	dying, such as o	cardiac or	respiratory a	rrast,	i	Approximate Interval Between Onsel and Death
er 🚡	diseasa or condition resulting in death)	a		(or as e consec	quance of):					1	DAYS
dicai Examiner	Sequentially list conditions	b	Due to	(or as a consac	mence of).						-8
EX	Sequentially list conditions, if any, leading to immediate ceuse. Enter Undarlying Cause (Disease or injury		500 10	(or as a corroac	quorica ory.					1	
//Medical	that initiated events resulting in death) Last	d	Due to (	or as a conseq	uence of):						
siciar	Part II. Other significant cond	itions contributing	to death but not re	sulting in the u	ndarlying cause	given in Part I.		23b. Did	tobacco use co	ntributa to	the cause of death
y Phys		RDIOMYC							Yas 25No		ably 4 ☐ Unknow
Completed by Physician/Me	INSULIN DEPE	NDENT	DIABET	EZ WE	WTUS.		_	24a. Was perfo	an autopsy prmed?	ava	re autopsy findings ilable prior to applation of cause eath?
Con	CHRONIC REI	VAL INS	UFFICIEN	icy				10	Yas 2 No	1 🗆	Yes 2 No
Be	25. Was cese referred to medi examinar?	Hospital:				Othor:		(Check only o			
Medical Certification: To Be Com	1 Yes 2 No  27. Mannar of Death 1 Natural 5 Pen 2 Accident inve	28a. D	1 Inpatient 2 Data of Injury Month, Dey Year)	28b. Tima of injury	28c. II	Other: 4 Nur njury at Vork?	28	Home 5 ☐ Residence 8 ☐ Other (Specify)  28d. Describe how injury occurred			)
Certification:	3 ☐ Sulcida 6 ☐ Cou	mined 288. P	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street end Number or Rural Route Number, City or Town, Stete)			
edical	29a. Cartifier 1 Certif (Check only 2 Medic	ying Physician: To at Examiner: On the and i	the bast of my kn ne besis of examin manner stated.	owledge, death ation and/or in	n occurred at the vestigation, in m	time, date and y opinion, deat	d place, an	d dua to tha at the time,	causa(s) and ma date and place,	anner as sta and due to	ated. the cause(s)
-	29b. Signatura and title of certi	fier RESIDE	NT		29c. Lice	anse number			29d. Data signa		
W	Ratio	1,000,000				P 13449			Jenterno	icic i	

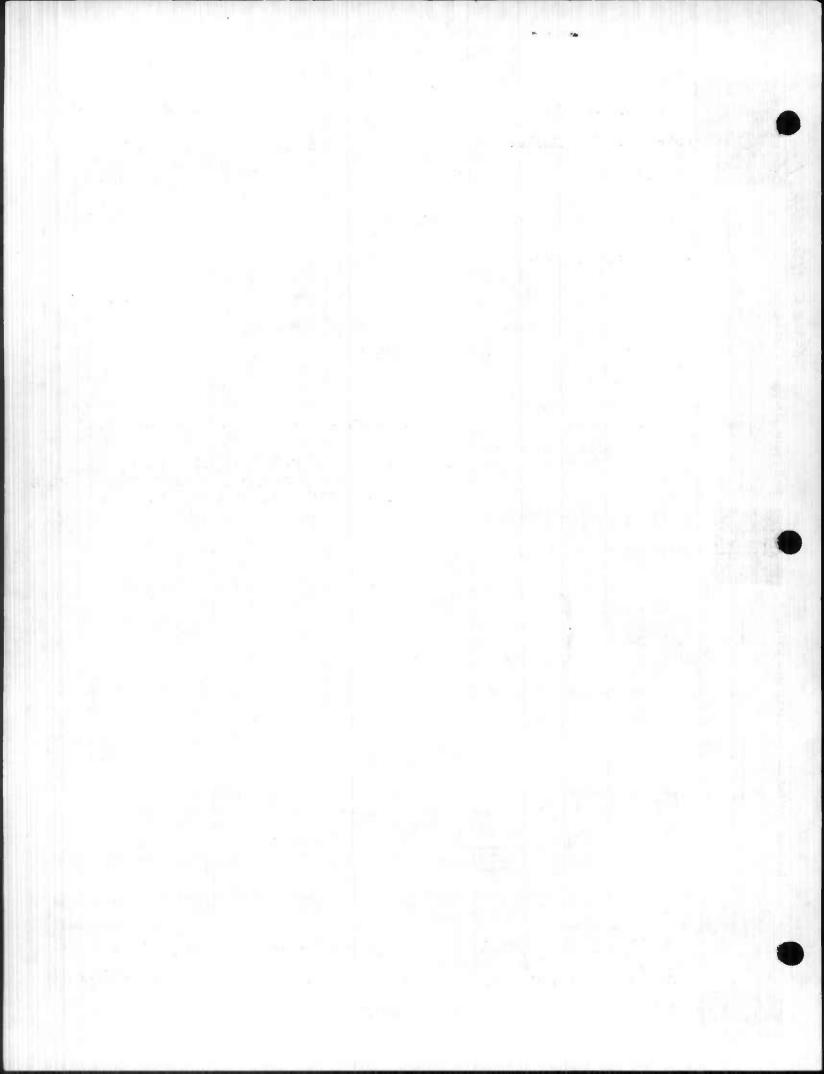


# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

							tificate		Death		eg. No.	3 2	. 5215
Physician		ecedent's Name	(First, Middle, La	st)						2. Date of Dea Month	lh Day	Year	3. Time of Death
/Medical	part	ERNA	RD 9	ELBER						SEPTEMBE	Le.	2000	06:40.
Examiner	40 5	acility Name (#	not institution, giv	e street and numbe	r)			4	b. City, Town, or Lo		4c. County		
		LEVINDA	LE					-	BALTIMO	RE		N/	/Δ
Funeral	5. S	ocial Security No		Sex 7. A	ige (In yrs. last	birthday)	If Under 1 Y		If Under 24 Hrs.	8. Date of Birth			lace (State or Foreign try)
Director		29-26-64 al Rasidence of	102	<b>X</b> M 2□ F	66	Yrs.	Months D	ays	Hours Min.	SEPT.1		Coun	NY NY
P	-	State	10b. County		10c. City, T	own or Loc	ation					1	Od. Inside City Limits
ahow de	5	MD	N/	/2	, n	3 F (T) T M	ODE						1 S Yes 2 □ No
the M	3		<u> </u>	A	Ь	ALTIM	_	4.			0-04:		**
£ 5 2 2	7	Street and Num		S AVENUE	#612		10f. Zip Co	oa.	21215		0g. Citizan of V		try?
deat	11.1	Marital Status		12. Was Deceden	t Ever in U,S.	13. V	as Decedent	of Hi	spanic Origin? (Spe n, Mexicen, Puerto I	city Yes or No-	14. Race	- Amaric	an Indian,
21215-0020 d within 72 hours after death v giene r than "natural", or home 234 the doce Examine must		Never Marrie	od 2⊠ Married	Armed Forces  1 ☐ Yes 2  If Yes, Give Year or Dates	] No		Yes, specify  Yes 25		Specify:	Hican, etc.)	Specify	k, White,	etc. HITE
nou in			15. Decedent's Ed			6a. Deced	ent's Usual O	ccupe	ation		16b. Kind of Bu	siness/Inc	dustry
1 21215-0 led within 72 ho tygiene. In the Med call Completed			fy only highest gra	de completed)		(Give I	ind of work d	one a	furing most of working)	ng			,
within then then then then then then then the	E	ementary/Secon		College (1-4or							T 31.1		
illed and a series	17.1	ather's Name (	First, Middle, Last		I A	TTORN	<u>ri</u>	- 1	18. Mother's Name	(First, Middle,	LAW Maiden Sumam	6)	
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Maryland 12 should be filed 12 should be filed 13 smarked othe treumatic event,			me/Ralationship (						and Number or Rura				
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0 00		Method of Disp		Removal from State	cemi	e of Dispos ete <i>ry, cr</i> em	ition (Name of atory or other	or r plac	e)	Data	20c. Location -	City or To	wn, Stata
Pag Int: h			5 ☐ Other (Specif			SHAL	OM CEM	ET	ERY 9	/10/00	TAYLOR	SVILI	E, MD
Saltin Semit. Pa Separtmen mportant: any injury	21.	Signature of Fur	Tal Service Lices	900		22.	Name and A	ddres	a of Facilia.				S., INC.
Depa limbo			7.00	2		00	OO DET	CMI	ERSTOWN R				
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	-	shock, or hear	t faiture. List only	one ceusa on each	line.	o not ome	1110 111000 01		g, •40, 140 00, and 0	. raopiratory arr			Interval Between Onset and Death
Physician												-	Origot aria Doatii
/Medical Examiner	dise	ediate Cause (I	-inal	SE	PSIS								I WEEK.
TST-130		Ilting in death)			Due to (or as	a consequ	uence of):						
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be executed cien and buriel-transit	Seq	uentially list con	ditions.	b	Due to (or as			-	001100				
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ficete be exe g physicien exe the burial-	Cau	initiated events		C	Due to (or as	a consequ	ence of):						
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box of any of the same of the				d									
death certile attending ad for use a										1			
hat the death certified by the attending detached for use a	Part	II. Other signific	cant conditions c	ontributing to death	but not rasultin	ig in the un	derlying caus	e give	en in Part I.				the cause of death?
that the detache detache										1 1 Y	es 2 No	3 Pro	bably 4@Unknow
N 2 68 0							The state of					045 141	
v requires been sign should be										24a. Was a perfor	med?	av	are autopsy findings allable prior to
has b												of	mpletion of cause death?
The I										10Y	es 2 No	1[	Yes 212 No
VITAL IN INCIDENT THE CONTINUES OF SECONDARY		Was case raterr	ed to medical			-	-		26. Place of Death	(Chack only or	na.1		
Or VICE Physicien: this certific ral director.		examiner?		Hospital:	ion OFF	Dutastian	3□ DOA	Oth				or /Fanail	Lab.
Physic chis of ral dire		Aannar of Death				b. Time of		Injun		28d. Dascribe h			y)
DIVISION OF VICE  Telescoperated the conflicted and Director: After this certificate led in by the funeral director, page Confileration: To Be Confideration: To Be Confileration:  1	<b>⊠</b> Natural	5 Pending	28a. Date of In (Month, D	ay Year)	Injury	М	Work	k? Yes 2□No			- 19		
the the	3	2 ☐ Accident 3 ☐ Suicide	investigation							204 Laurtina (C	tened and then t	and Die	I Boute Number
A POST I		4 ☐ Homicida	datarmined	286. Place of It	njury - At nome atc. <i>(Specify)</i>	, tarm, stre	et, factory, of	TICE		City or Tow		er or mure	I Route Number,
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he Hospi in 24 hou he Funer pletely fil	29a	Certifiar (Check only	Certifying Ph	ysician: To the bes	t of my knowled	dga, daath	occurred at the	ha tim	na, data and place, a pinion, daath occurre	and due to the c	ausa(s) and ma	nner as s	tated.
the first		one)	7	and manner	stated.		and it	, 이					
To the trop	29b.	Signature and t	itle of certifier				29c. Li	cense	e number	2	9d. Date signe	d (Month,	Day, Year)
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State		(3)		N. P.		E	1						
Registrar		SI	P 1 5 2	1111	neva	1	200	tole	6				



sician			/00 yf		Certif	icate of	Death		Re	eg. No.	] 2	
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ledical aminer		ANNIE MAE H		ber)			4b. City. To	wn. or Lo	9/8/ ocation of Death	2000 4c. County	v of Death	9:30 A.1
mmer	-	(HOME) 181 MOU		OAD			PASA				.CO.	
eral	1	5. Social Security Number 6.		. Age (In yrs.	M	Under 1 Year onths Days	if Under	24 Hrs. Min.	8. Dete of Birth (Month, Day,			ace (State or Foreign
tor	-	212-46-9105 Usuel Residence of Decedent	TEIM ZUAF	65	Yrs.				6-2-35		MD.	•
	-	10a. Stete 10b. County		10c. City	y, Town or Location	on					10	d. Inside City Limits
ctor		MD. A.A	. CO.	P	ASADENA	A						XX Yes 2□No
Director		10e. Street and Number			1	Of. Zip Code			16	Og. Citizen of	What Count	ry?
Funeral		L81 MOUNTAIN R	OAD 12. Was Deced	lent Ever in II	S 13 Wee	21122		ain? /Sn	U Vos or No	S.A	ce - America	n indian
		1) Never Married 2 Married	Armed Ford	es?					ecify Yes or No- Rican, etc.)		ck, White, e	
A P		3 ☐ Widowed 4 ☐ Divorced	if Yes, Give Year or Det	es:	10	Yes X No	Specify:			Specif	BLAC	CK
Completed		15. Decedent's (Specify only highest g			16a. Decedent' (Give kind	's Usual Occu d of work done NOT use retire	pation during mos	t of work	ing	16b. Kind of B	usiness/Indu	ustry
O E		Eiementery/Secondery (0-12)	Coilege (1-4	4or 5+)		EMAKER				ц	OME	
BeC		17. Father's Name (First, Middle, Las	st)		1101112	311111111111		er's Name	(First, Middle, N			
To		FRANK HAND	Y				LIZ	ZIE	HANDY			
		19a. Informant's Name/Relationship	(Type, Print)						al Route Number,			Code)
	2	ETHEL THOMAS 20a. Method of Disposition		20b. P	iace of Dispositio	n (Name of		DAD	PASADE	NA MD	-	
		1 Auriai 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	Removei from St	ate	emetery, cremato							
DOCE.	177	21. Signature of unoral Service Lic		M'.	22. Na	me and Addr	ess of Facilit		/14/00 P BROT	MAGO:	THY N	RAL HOME
8		Mid G	SIL		130	O EUT	'AW PI	LACE	BALTO	, MD.	2121	.7
		23a. Park Enter the disease, or co shock, or heart failure. List onl	mplications that cau y one cause on eed	used the death ch line.	. Do not enter th	e mode of dyl	ing, such es	cardiec o	or respiratory arre	st,		Approximate Interval Between Onset and Death
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er		immediate Cause (Finai	111.00	1 = 5	2.	1 /	- KA	2		2/		
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		disease or condition	a. Mye	Due to (or	ras a consequent	1 /r 00 off: 00 G	VF4	20	TION	v		
<u></u>		disease or condition resulting in death)	a. Mye	TRA	r as a consequent	ce of):	UPG	20	TION	v .		
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dical Examiner		disease or condition	a. Myc b. M1- c. Cor	Due to (or	r as a consequent	ce of):	UPG	Re 17	TON Fact	v		
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To Be Completed by Physician/Medical Examiner	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Sequentially list conditions, france, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Part II. Other eignificant conditions  25. Was case referred to medical examiner? 1   Yes   2   No  7. Manner of Death 1   Natural   5   Pending investigating investiga	Hospital: 1 Inp.  28a. Dete of (Month, 9 & 28e. Place of building)  hystofan: To the bearminer: On the basis	Due to (or Due to (or	r as e consequence r as a conseq	ce of):  ce of):  iying cause give the control of t	26. Place her: 4 Nu ry 4 Yes 2 1	of Death rsing Hor No	23b. Dtd tol  1  Ye  24a. Was ar perform  1  Ye  (Check only one to the cattle of the	bacco use co  a 2 No  a autopsy  ed?  s 2 No  a utopsy  ed?  s 2 No  ed Oth  w Injury occur  eet and Numb  State)  use(s) and ma  te and piece,  dd. Date signe	anner as steamed and due to t	the cause of death?  ably 4 Unknown  e autopsy findings lable prior to pletion of cause seth?  Yes 2 No  Route Number,  ted. he cause(s)



Please Type of Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Month Vear :15 pm RANDOLPH HATCHER 9-4-2000 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) 1302 McCULLOH ST. (HONE) BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/11/33 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Deys Months Hours 1# M 2□ F W.V 216 30 7127 Yes Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Yes 2□No MD. BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1302 McCULLOH STREET 21217 USA Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes H No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 # No Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) NONE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) WILLIE HATCHER MILDRED HATCHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) LOUISE PRICE 905 W. BARRE ST. BALTO. MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT. ZION 9/13/2000 LANSDOWNE, MD. 22. Name and Address of Facility
ESTEP BROTHERS FUNERAL HOME P.A. 21. Signature of Fund Service Licensee 1300 EUTAW PL. BALTO. MD. 23a. Part1. Enter the disease, or complications that ceuse the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last as a consequence of): Due to (or es e consequence of): 23b. Did tobacco usa contributa to the causa of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. injury et Work? 1 ENeture 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurei Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specity) 4 Homicide

**Examiner** certificate be executed Division of Vital Records, P.O. Box 68760.

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**Physician** /Medical

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altimore, Maryland 21215-0020

Registrar

29a. Certifier

2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. 29b. Signature and life of certifier

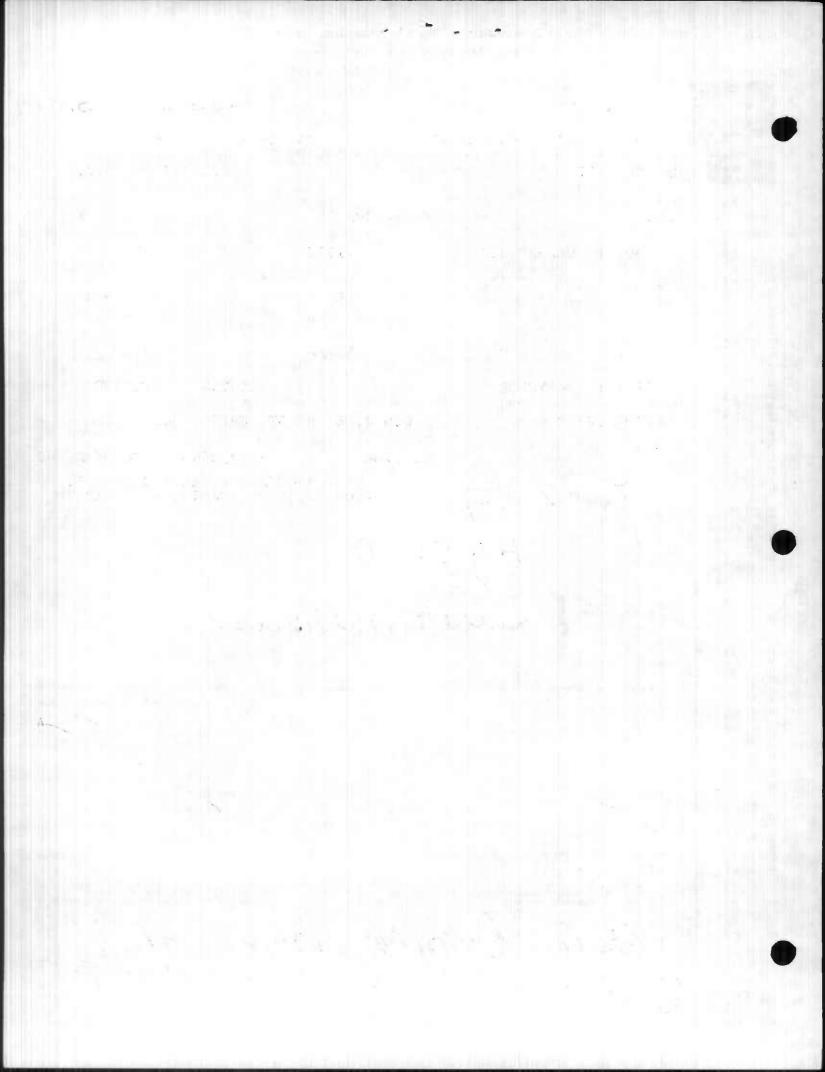
29c. License number

🐔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es steted.

29d. Date signed (Month, Day, Year)

30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Prin Pate filed (Month, Day, Year) EP 1 5 2000

32. Registrar's Signature



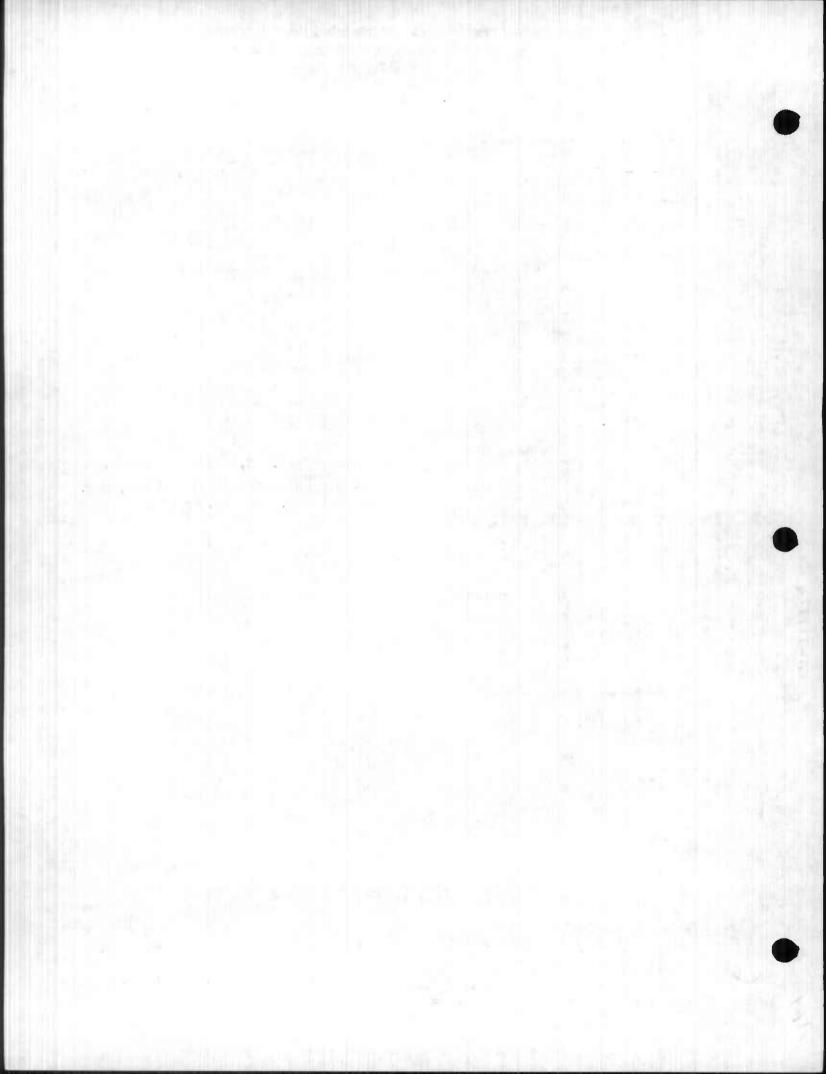
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day William E. Hisley **Physician** September 12,2000 5:30 PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Eastpoint Rehab and Nursing Home Eastpoint Baltimore H Under 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours 1₹ M 2□ F Yrs 216-07-6367 90 Director August 8,1910 Maryland Usuai Rasidenca of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Baltimore Dundalk 288-4 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? 23s or 7551 Berkshire Road 21224 Funeral United States 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Biack, Whita, atc. Barnet 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒No 1 Navar Married 2 Married 21215-0020 b 1 ☐ Yas 2 ☑ No Specify: Specify Aq % Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiana. Elemantary/Secondary (0-12) Collega (1-4or 5+) Telephone 12 Years Executive Company Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Pages 1 and 2 should be formatted of the formatter of Health and Mental Hearth II them 27 is marked other traumatic even Be Walter Hisley Elizabeth Fisher 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiting Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Wendell L. Wiland 3701 North Point Road Lot 54 Dundalk, MD (Friend) 21222 Baltimore, 20b. Piaca of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 Buriel 2 Crametion 3 Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Oak Lawn Cemetery Sept. 16,2000 Baltimore, Maryland 21. Signature of Funeral Sarvice Licenses 22. Name and Addrass of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 296 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or haart feilure. List only one cause on each line. Approximata Intervel Between Onset and Daath **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical Examiner Examiner eris scerose certificate be executed Sequantially list conditions, if any, leading to immediata causa. Enter Underlying Causa (Diseasa or injury that initiated evants resulting in death) Last Dua to (or as a consequence of): the attending physician Physician/Medical Due to (or es a consequance of): 28 68 Box The law requires that the death P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown yd bengis Records, þ 24b. Wara autopsy findings availabla prior to completion of causa of death? 24a. Was an autopsy performed? Completed 219 No 1 Yas 1 ☐ Yas 2 ☐ No of Vital Be 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatienf 3 DOA Othar: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) edicai Certification: To 1 Yas 2 No After this 28a. Data of Injury (Month, Day Year) luneral 27. Manner of Death 1 Watural 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred at or Attending P after death.

I Director: After to in by the funer. Division 5 Panding investigation 1 Yas 2 No 2 Accidant 6 ☐ Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifiar one)
29b. Signatura and title of certifier 29c. Licansa number 29d. Data signad (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELLWOOD AVE, BALTO, MD 21224 MELITO M. TORRES, MO 44 32. Registrar's Signatura State oaks Registrar

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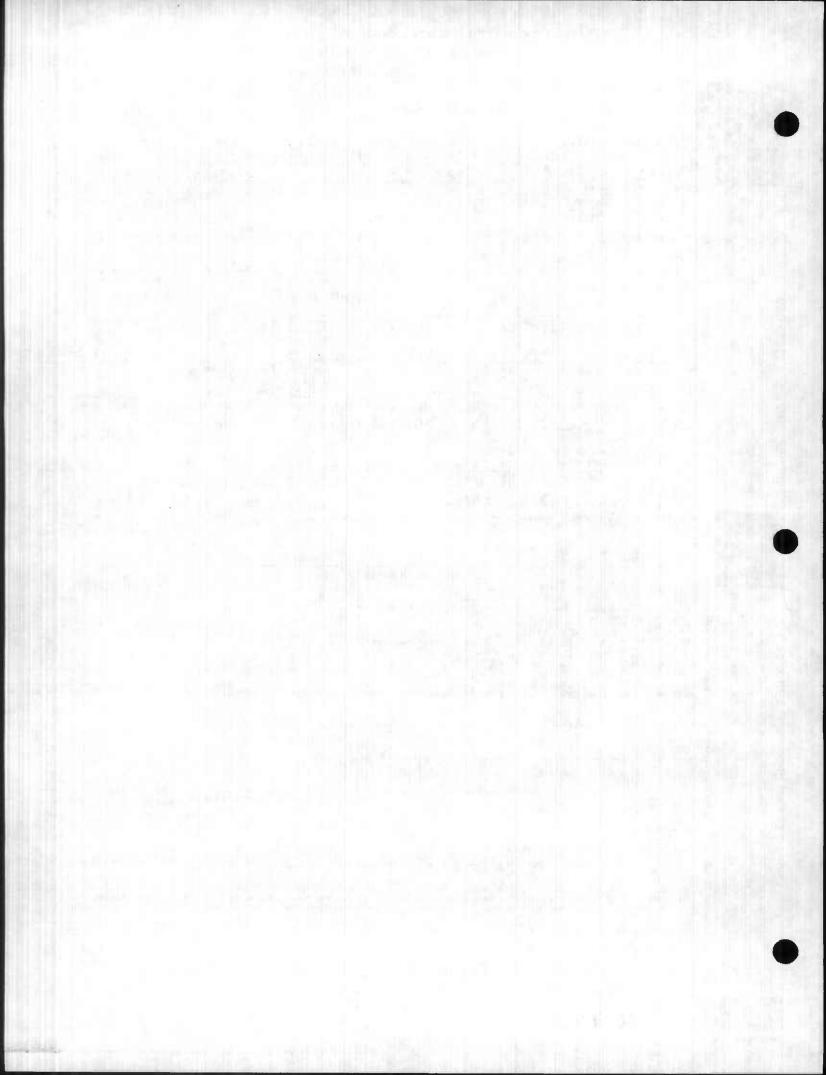
**DHMH 16 Rev 6/95** 

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene 0 29219

			Certificate of I	Death	Reg. N	lo.	
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Physician /Medical	William W.	JOHNSON, S	, R,	5	FRIEMBOR	13 200	
Examiner	4a Facility Name (If not institution, give str			4b. City, Town, or Locat		c. County of De	eath
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Funeral	5. Social Security Number 6. Sex	7. Aga (In yrs. lest birtho	Months Devs	If Under 24 Hra. 8. Hours Min.	Date of Birth (Month, Dey, Yea AN, 19, 1	9. 6	Birthplace (State of For Country)
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Dir Be	10e. Street and Number	. 4.	10f. Zip Code	-		Citizen of What	Country?
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ritems 23e or 25e-fr sher must be notified Funeral Directo		. Was Decedent Ever in U,S. Armed Forces?	If Yes, specify Cubi	lispanic Origin? (Specif an, Maxican, Puerto Ric	y Yes or No- an, atc.)	Black, W	mericen Indian, /hita, etc.
Manna Dy F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yas 2 ☐ No If Yes, Give	1 Yas 2 No	Specify:		Specify:	Nack
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and a	4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Garri	22. Nama and Addre	00110	18(00)00	JIN 921	1,1112 1.11
DOS THE	21. Signature of Furieral Service Licensee		march Fu	weed Ho	ne Wost	. A	
- Telephone	Dufus 13	. Harri	1000000	abash Au	e Bal-	o. Md	51512
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ysk	Part II. Other significant conditions contri	buting to death but not resulting In the	he underlying ceuse giv	ren in Part I.	23b. Did tobac	co use contrib	ute to the cause of d
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Deeth 3. Time of Death Day Jackson Month Yaar **Physician** Clifton September 12,2000 06:50 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, giva street and number) Examiner Medic- / Center Johns Hiptuns 7. Aga (In yrs. last birthday) If Under 1 Yaer If Under 24 Hrs. 8. Data of Birth Months Days Hours Min. (Month, Day. Bayview Birthplece (Stata or Foreign Country) 5. Sociel Security Number 6. Sex **Funeral** 12M 20F 213-52-0085 52 MD Director Usual Rasidance of Decedant the Meryland 10b. County 10c. City. Town or Location 10d. Insida City Limits 10a. Steta 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yas 2 No MO BALTIMORE Funeral Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? Items 23s or filed within 72 hours after death with USA 1417 MONTPELIER 21218 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Detas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 PNever Married 2 Married Maryland 21215-0020 "natural", or 1 Yas 2 PNo Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada complated) permit. Peges 1 end 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "na any injury or other traumatic event, fire Illing once. Elemantery/Secondary (0-12) College (1-4or 5+) CHASE CUT-RATE MANAGER 10 th gRADE NA 18. Mothar's Neme (First, Middle, Maidan Sumama) 17. Father's Name (First, Middla, Last) BERNARD GERA / dINE JACKSON YOUN9 19a. Informant's Name/Ralationship (Type, Print) (5/5/ER) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 1417 MONTPELIER ST BALLO MD 21218 BLACKWELL GWENDOLYN Baltimore, 20b. Place of Disposition (Neme of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata MT 00 GLEN BURNIE CALVARY 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility FUNERAL HOME 21. Signature of Funeral Sarvice Licensee BETTS 1129 N. CAROLINE ST BALTO. MD Mrued 23a. Part1. Enter the disease, or complications that ceused the daeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** seps.s /Medical Immediata Ceusa (Final disaasa or condition rasulting in death) Examiner Due to (or as a consequence of): lomerular scharst Examiner Sequentially list conditions, if any, laading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last that the deeth certificate be execu hronic Narcotism P.O. Box 68760. ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 ☐ Unknown bematom a Division of Vital Records. Be Completed by The law requires 24b. Were autopsy tindings available prior to completion of cause of death? 24e. Wes en autopsy performed? deel renous thomb. 1 □ Yas 2 □ No this certificate 1€ Yes 2 No Physician: 25. Wes casa referred to medical axaminar? 26. Pleca of Death (Check only ona) Hospital: 1 Hopatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yes 20 No Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 27. Mennar of Death 28b. Time of After 5 Panding invastigation or Attending 1 Netural 2 Accident 1 Yas 2 No death. s after death.

I Director: A din by the fu 6 Could not be datamined 3 ☐ Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I Medical 1 Certifying Physician: To tha best of my knowledge, deeth occurred at tha time, data and place, and dua to tha cause(s) and mannar as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner steted. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signaturenenal titla of certifier 29c. Licanse number 114100 20305 30. Nenia and address of person who completed cause of death (Itam 23a) (Type, Print) Shula Gonzalgo, 4940 Eastern Ave Baltime, mo 21224 JIBMU MO 31. Dete filed (Month, Day, Year) SEP 1 5 2000 32. Registrar's Signatura Registrar

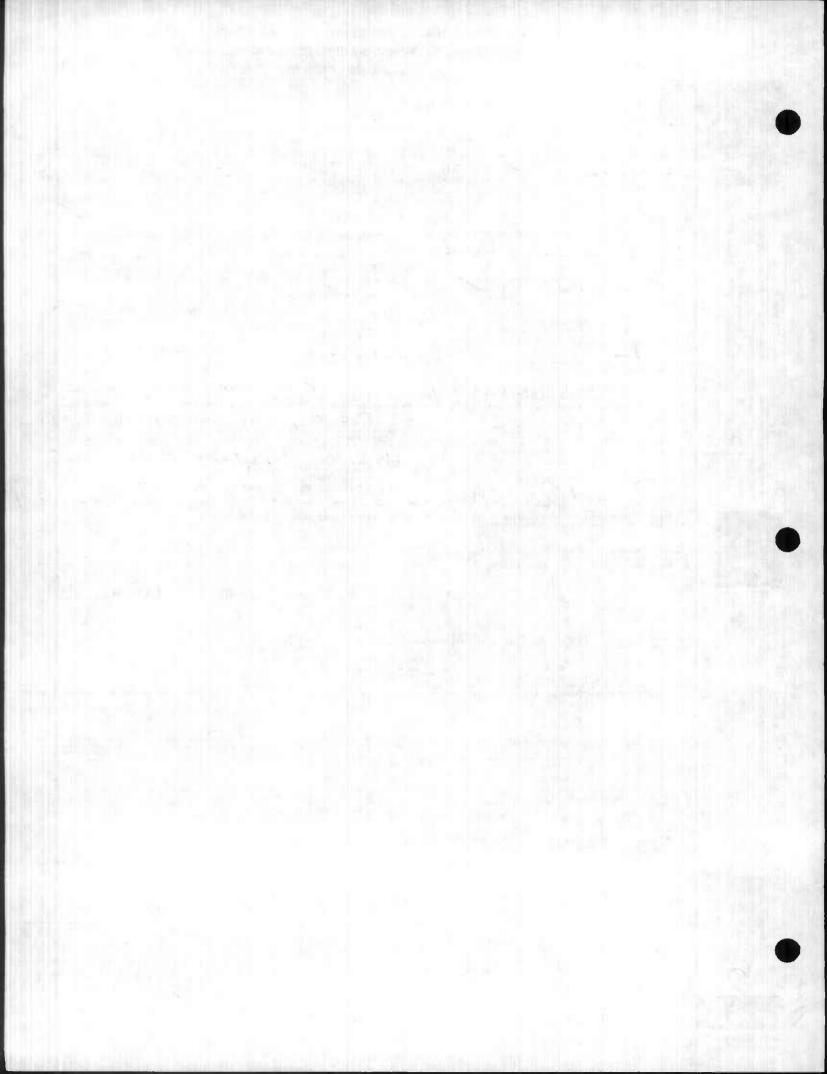
ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** L15A KENNEDY 09 12 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GOOD SAMARITAN HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) OCT- 25 / 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 10 M 20 F Months Hours 39 220-82-6612 1960 Mary land Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 Nas 2 No Baltimore Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? munt be n 532 E. coldspring Lane S. A 21212 14, Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 (D) No If Yes, Give Yeer or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cubap, Mexican, Puerto Rican, etc.) 11. Merital Stetus Black, Whita, atc. 1 Never Married 2 Married 1 Yes 2 No Specify. 21215-0020 8 Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Hygiene. other then "neturn ent, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Elementary/Secondery (0-12) Collega (1-4or 5+) Baker Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fi of Health and Mental H I flem 27 is marked off r other traumetic ever Florestine Samuel Hay wood Kennedi 19a. Informant's Name/Relationship (Type, Print) Council 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto MD 532 E, Cold Spring Lane Moore orestine 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State Pages 1 nent of H Important: If it any injury or o 1 Burlel 2 □ Cremetion 3 □ Removel from State Baltimore Co. Woodlawn Cemeter Sept. 20,00 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Eacility Ronald At GRAYSON Funeral Service Ronald At GRAYSON Funeral Service 8312 Liberty Road Balto, MD 21244 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical DAYS SEPSIS Examiner Due to (or es e consequence of): Physician/Medical Examiner DAYS STAGE ACQUIRED IMMUNODEFICIENCY SYNDROME Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): 68760 Due to (or as a consequence of): Box Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yas 2 No 3 Probably 4 Unknown Records, Be Completed by 24b. Ware autopsy tindings 24a. Was an autopsy available prior to completion of causa of death? 1 Yes 2 No 1 Yas 2 No of Vital 25. Was case reterred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 Malinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28c. Injury at Work? 27. Manner of Death Hospital or Attanding Pt
 24 hours after death.
 Funeral Director: After th
 Jethor in by the funeral 28b. Time of 28d. Describe how Injury occurred Division 1 Naturat 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely f (Check only one) and manner stated. 29b. Signature and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) Bhart RESIDENT P13449 09-12-2000 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

BHARTI ABICHANDANI. MD GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BOULEVARD BHARTI ABICHANDANI, MD BALTIMORE, MD 21239 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State SEP 15 porks 2000 Registrar

DHMH 16 Ray 6/95



Box 68760. P.O. Records. of Division

VIOLET KLEINSMITH

00

SEPTEMBER

State Registrar

31. Date filed (Month, Day,

TARIQ MAHMOOD

29b. Signature and title of certifier

2300 DULANEY VALLEY RD. 32. Redistrar's Signature

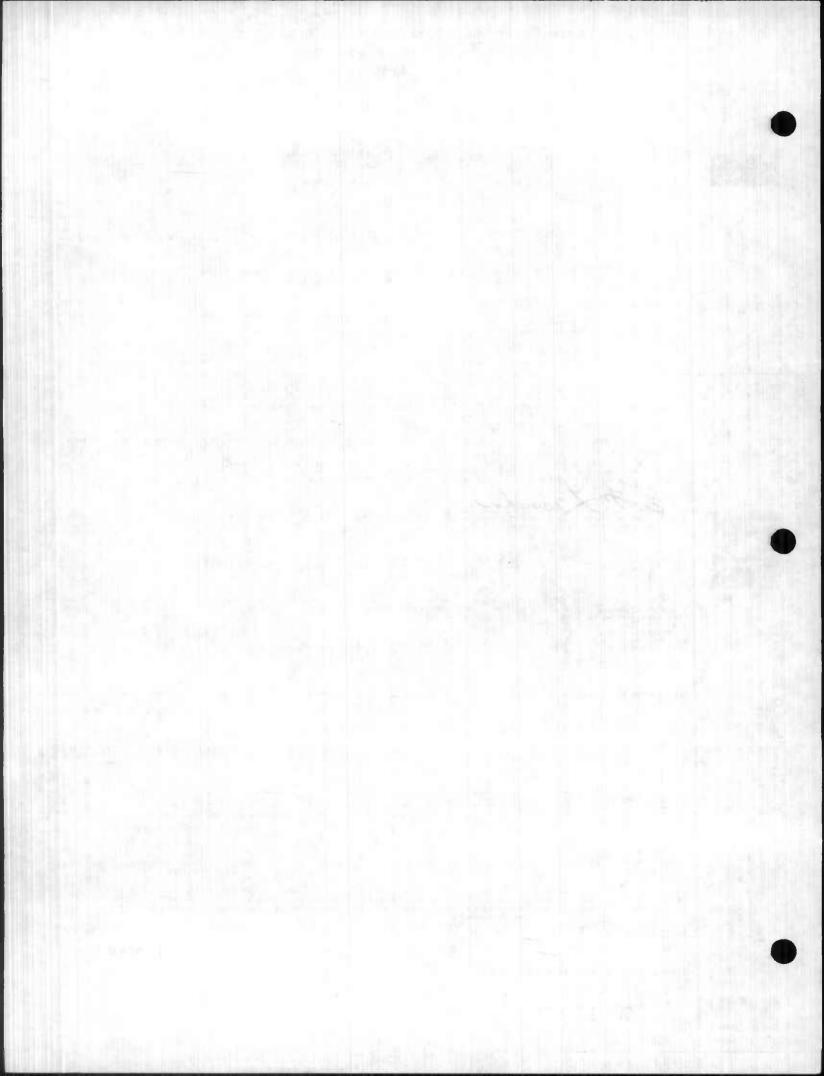
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TIMONIUM, MD 21093

29c. License number

29d. Data signed (Month, Day, Year) 9/8/00

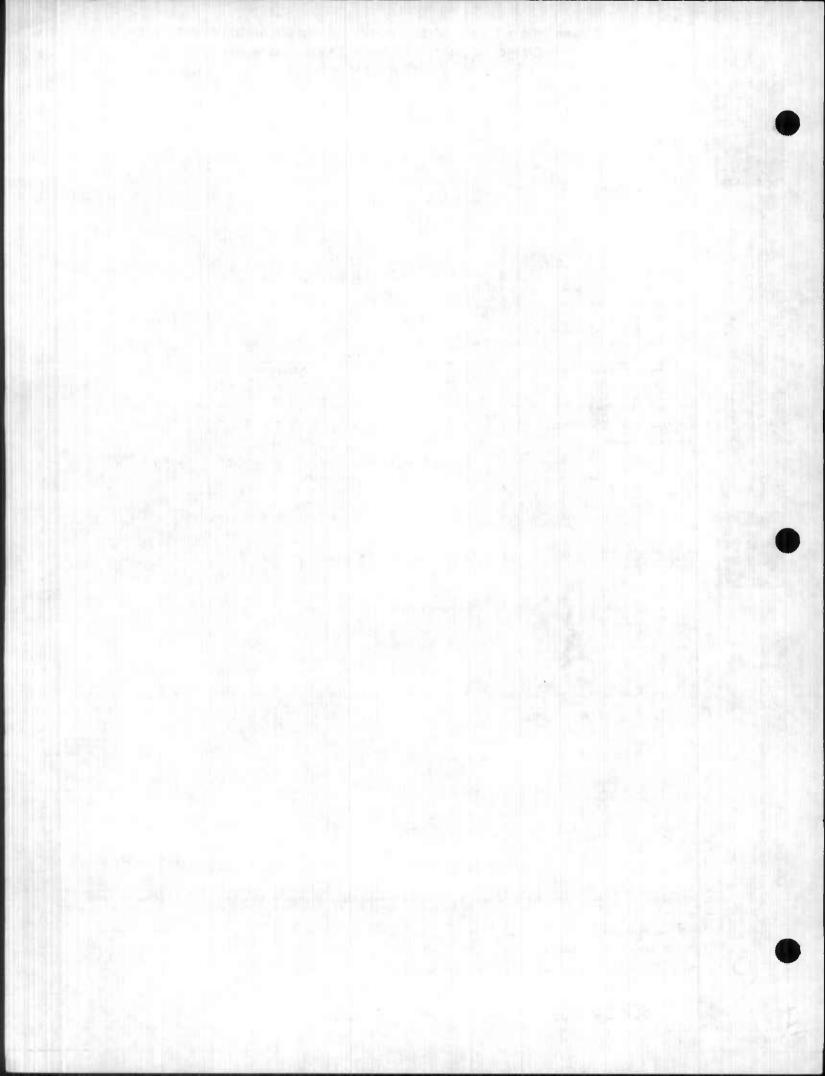
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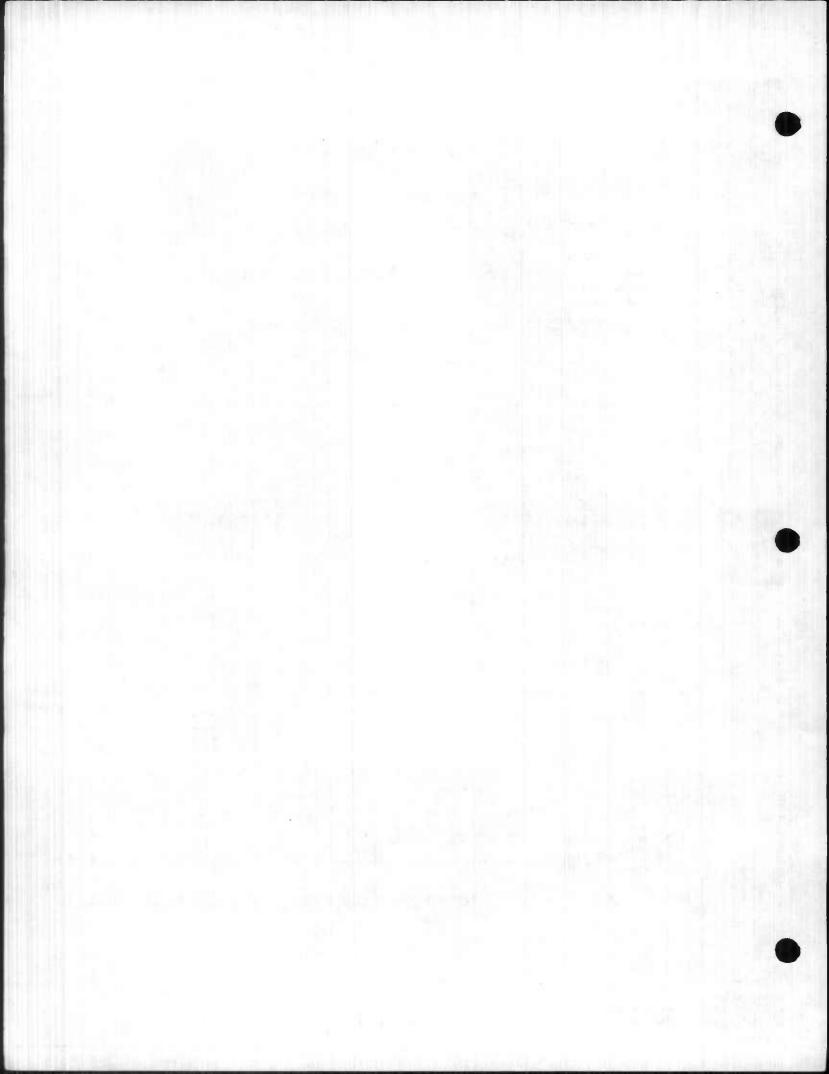
State of Maryland / Department of Health and Mental Hygiene 29223

	AMEND I	TEM: #3 I			9-19-00	Went	tificate of	Death		2. Date of Deat	ng. No.		3. Time of E	Death
	Physician		genia D. K							September	Day	Year	10:00/44	
	/Medical	4a Facility Name (If			ber)			4b. City, Tow	-	ation of Death	4c. County			PM.
	Examiner		Baltimore					Towson			Baltim			
ı	Funeral Director	5. Social Security Nu 219-26-4261	1	9x 7 □ M 2ŪXF	71. Age (In yrs. last	Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birth (Month, Dey, July 29	Year) 1929		place (State or intry) ISY I Vania	Foreign
	pua .	Usual Residence of I	10b. County		10c. City, T	own or Loc	ation	-			10d. Inside City Limits			Limits
	f show	Md.	Baltimore			ville							1 ☐ Yes	
	with the Maryland a or 28a-f show the notified a	10e. Street and Num			Killigo	71110	10f. Zip Code		V	10	Og. Citizen of W	Vhat Cou	intry?	
	3a or	7906 Rec	Istone Rd.				21087				U:	SA		
Maryland 21215-0020	within 72 hours after death vana. than "natural", or flame 23s than death and the man and	11. Marital Statua  1 Never Marrie 3 Widowed 4		12. Was Deced Armed Ford 1   Yes 2 If Yes, Give Year or Dat	No No		Vas Decedent of the Yes, specify Cub		in? (Spec Puerto R	0				
2-0	ed within 72 ho ygiene. ser than "naturn rt, rre tredien Completed	(Specif	15. Decedent's Ed	ucation	1	6a. Decede	ent's Usual Occup	pation	of workin	0	16b. Kind of Bu	siness/Ir	ndustry	
7	within than the	Elementary/Secon		College (1~	4or 5+)		ind of work done O NOT use retire	d)	O WOTKIII		F 1			
2	7 2 4	12				School	Teacher			4572	Educati			
and bug	0 = 0 5	17. Father's Name (F	11/25/19							(First, Middle, A	Meiden Sumam	Θ)		
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Mai	2 9 9 9	19e. Informent's Ner					Address (Street					State, Zi	ip Code)	
	f Health fram 27 other tr	Mr. Peter N. 20a. Method of Dispo		Husband	20b. Place	e of Dispos	Redstone ition (Name of		gsvii		20c. Location -	City or T	own. State	
Baitimore,	Pages ant of mt: If it ry or o	1 X Burlal 2 □	Cremation 3  Other (Specify		tate	Orthod	ox Cemeter	У			Wood1awn			
Bai	permit. Departm Importal any Inju	21. Signature of Fun	eral Service Liden	500		22.	Ruck Tov	vson Fun	eral	Home, Inc , Md. 212	ina			
		23a. Part1, Enter the shock, or heart	disease, or comp	olicetions that ca	used the deeth, I	Do not ente	r the mode of dyi	ing, such as c	ardiac or	respiratory arre	est,		Approximete Interval Betw	1007
	Physician	SHOOK, OF FIGURE	Tondro. Liagony	JII 42 030 011 60	OTT III TO.							1	Onset and D	eath
	/Medical	Immediate Cause (Final disease or condition Introduced (knowley)									5 Hou	RS		
	Examiner	resulting in death)		G	Due to (or as			0				1		-
	P = 0			h								1		
	be executed ician and buriel-transit	Sequentially list con-	ditions,		Due to (or as	s a consequ	ience of):					1		
68760,		Sequentially list con- if any, leeding to im- cause. Enter Underl Cause (Disease or in	ying	c										
387	physician s the burie	that initiated events resulting in death) Le			Due to (or as	a consequ	enca of):					1		
	ding p			d								1		
Box	attending for use a						12.55			1		- 1		
P.O.	The law requires that the death certicate has been signed by the attending page 2 should be detached for use a Completed by Physician/M	Pert II. Other signific	ant conditions co	ontributing to dea	th but not resulting	ng in the un	derlying cause gi	ven in Part I.			_/		to the cause of	
	signed b	Mechal	CA	Herh	Vicerati	n lo	letis,			101	es 2⊡′No	3	obably 4 🗆 L	MINIOWII
Vital Records,	or sign	0. 1	1	6.1	1	C-	6-11		^	24a. Was a	n autopsy	24b. V	Vere autopsy fir vailable prior to	ndings
00	las been si 2 should npleted	1 Jeulon	enbound	N (0)	1471 -	squau	you (el	CA	1	perform	near /	C	completion of ca	luse
Re	certificate has rector, page 2 Be Comp	lest	Bron A						4	1 D Y	s 2 No	1	□Yes 2□1	No
tai	entificat sctor, p	25. Was case referre	ed to medical					26 Place	of Death	(Check only on				
>		examiner?	lo	Hospital:	patient 2□ER	VOutpatient	3□ DOA Ot	her:		ne 5 Reside		er (Spec	eify)	
of	Ing Physical After this funeral di	27. Manner of Death		28a. Date of		Bb. Time of Injury	28c. Inju		-	28d. Describe ho				
Division	Attending I or death. ector: After by the funer iffication	1 Netural 2 Accident	5 Pending investigation		, buy roun	rigary		Yes 2□N	lo					
<u>&gt;</u>	or de recto by th	3 Suicide	6 Could not be determined	200. Flaca c	of Injury - At home	e, larm, stre	et, factory, office		2	81. Location (St City or Town		er or Ru	ral Route Numb	oer,
ā	Ce in Die			00110111	g, oto. (Diposity)									
	To the Hospital or Attanding P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	(Check only 2	Certifying Phy	iner: On the bas	sis of examination	dge, deeth	occurred at the tiestigation, in my	ime, dete end opinion, death	place, a	nd due to the ca	ausa(s) and ma ate and placa,	nner as and due	stated. to the cause(s)	
	within 2 within 2 To the complet	one) 29b. Signature and ti	tle of partition	and pranne	er Steted.		29c, Licen	se number	-	2	9d. Date signed	d (Month	n, Dey. Year)	
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	10	30. Neme and address	ss of person who c	completed cause	S L L	39) (Type, P	(mnt)	11.	d.	Md 71	11)			
	State	31. Date filed (Month	Day_Year)	32/Re	gistrar's Signature	9 /	1	5 m	111	1-10-1	. /			
Ţ	Registrar	31. Date filed (Month	1 5 2000	ST	eva /	0	sporks							



State of Maryland / Department of Health and Mental Hygiene 29224

	1. Decede	ent's Neme (First, Mide	dle Las	43								2. Date of D		_		( D th
				4)												ima of Death
an a'	Kenneth H. King						SEPTEMBER 12, 2000 10:15PM									
al er	4a Facilit	y Nama (If not institution	on, give	street and	i number)					4b. City, To	wn, or L	ocation of Dea	-			
Ç!	310	3 Bero Roa	d							Baltin	nore		Balti	more	e	
		Security Number	6. Se	ЭX	7. Age (	'In yrs. last b	birthday)	If Unde	er 1 Year			8. Data of B		9 Bi	irtholace (	Stata or Forei
		-28-1397		M 2□ I		78	Yrs.	Months	Days	Hours	Min.	OCTOBE!	irth (192 ) 192	1 6	Country)	YLVANI.
1		sidence of Decedent				70						POTOBE	,	7 -	LIMID	LUVINI
١	10a. Stete		y		1	Oc. City, To	wn or Lo	cation							10d. Ins	ide City Limit
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l	319	3 Bero Roa	d					21	227				United	St	ates	
	11. Merita	l Status		12. Was D	Decedent Every Forces?	er in U,S.	13. \	Was Dece	edent of h	Hispanic Ori	gin? (Sp	ecify Yes or N Rican, etc.)		ack, Wh	nerican Ind	isn,
	1 🗆 N	evar Married 2 Ma	mied		es 2 No Give			1 Yes				, , , , , , ,			Whit	• •
	3 🗆 M	idowed 4 ☐ Divorce	d	Year o	or Dates:			ILI Tes	200110	Specily.			Speci	my:	MILT	. e
		15. Decede	nt's Ed	ucation		16	a. Deced	dent's Usi	ual Occup	petion			16b. Kind of	Businas	s/Industry	
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ĺ	CIBILION	12		Colleg	Je (1-401 5+)		Ar	cmy	Ordi	inance			Mili	tary	,	
ı	17. Father	's Name (First, Middle	, Last)									a (First, Middle	e, Maiden Suma			
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\Omega\) Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Tima of Death **Physician** Doris Elinora Leubecker Hember 4c. County of Peath 2000 /Medical 4e Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner 9. Birthplaca (Stata or Foraign Country) Franklin S. Social Security Number Salvare If Under 1 Yaar 8. Data of Birth (Month, Day, Year) Aug. 17, 1924 f Under 24 Hrs. 7. Age (In yrs. last birthday)
76 Yrs. **Funeral** Deys Months Hours 1□ M 20 F Maryland 217-20-0411 Director Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 8 Cedar Chip Court 21234 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puarto Rican, atc.) 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yas, Giva 14. Race · Amarican Indian, 11 Merital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th Grade Collega (1-4or 5+) Secretary University 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Hudson Smith Anna Marie Strieler 19a, Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Ms. Joanne M. Leubecker (dghtr) 8 Cedar Chip Ct., Baltimore, MD 21234 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cramation 3 Ramovel from Stata Parkwood Cemetery 9/18/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility
Schimunek Funeral Home, Inc.
9705 Belair Rd., Baltimore, 21. Signature of Funaral Sarvice Licensee Mark 8 MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata tntarval Batween Onset end Deeth Physician /Medical Immediata Causa (Final diseasa or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): -ongestive HEar Physician/Medical Dua to (or as a consequence of): 950 signed by the atter Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ulMonary Completed by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? nera 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case lefarred to medical axaminer? B 26. Placa of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA To Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) 1 Yas 2 No this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b, Tima of tnjury 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending Invastigation or Attending death. 1 ☐ Yas 2 ☐ No 2 Accident after death Director: 6 Could not be datermined 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicida 24 hours a Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical completely (Check only one) within 2 the state of 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifiar 53547

**DHMH 16 Rev 6/95** 

Box 68760,

P.O.

Records,

of Vital

Division

Registrar

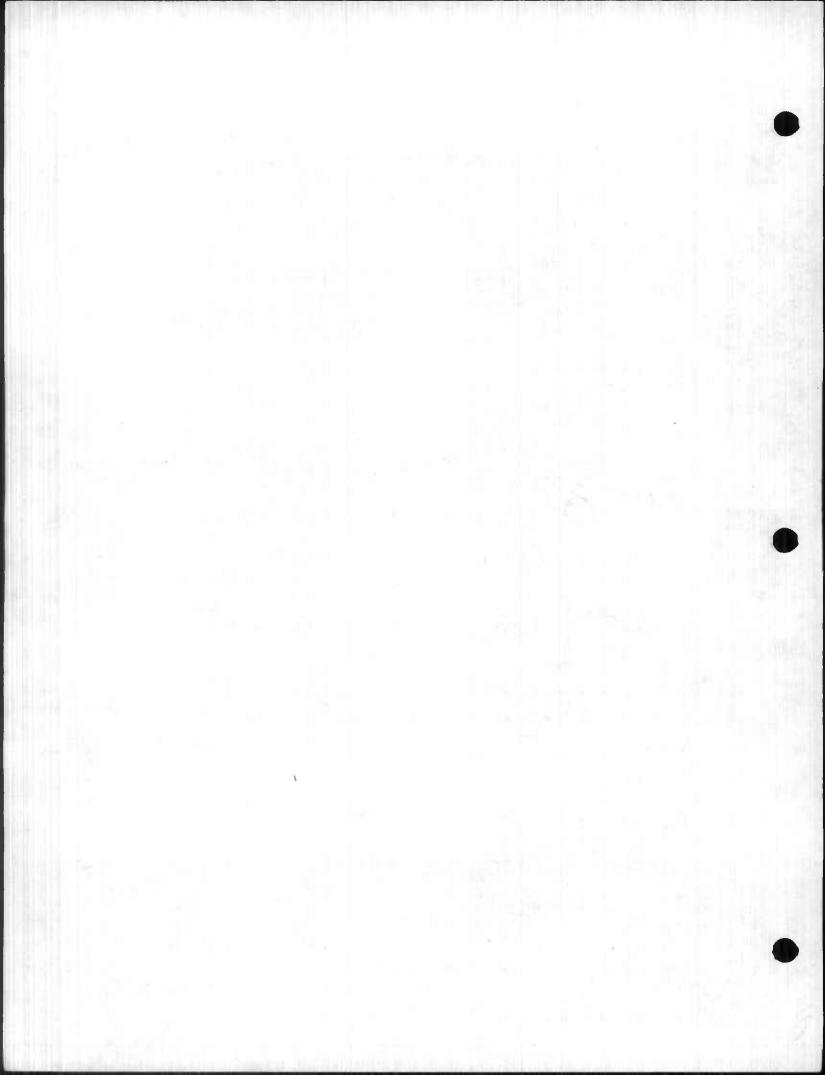
31. Date filed (Month, Day, Year) SEP 1 5 2000

Santay Jagannath 9000 Franklin 32. Registrar's Signatura

9/14/00

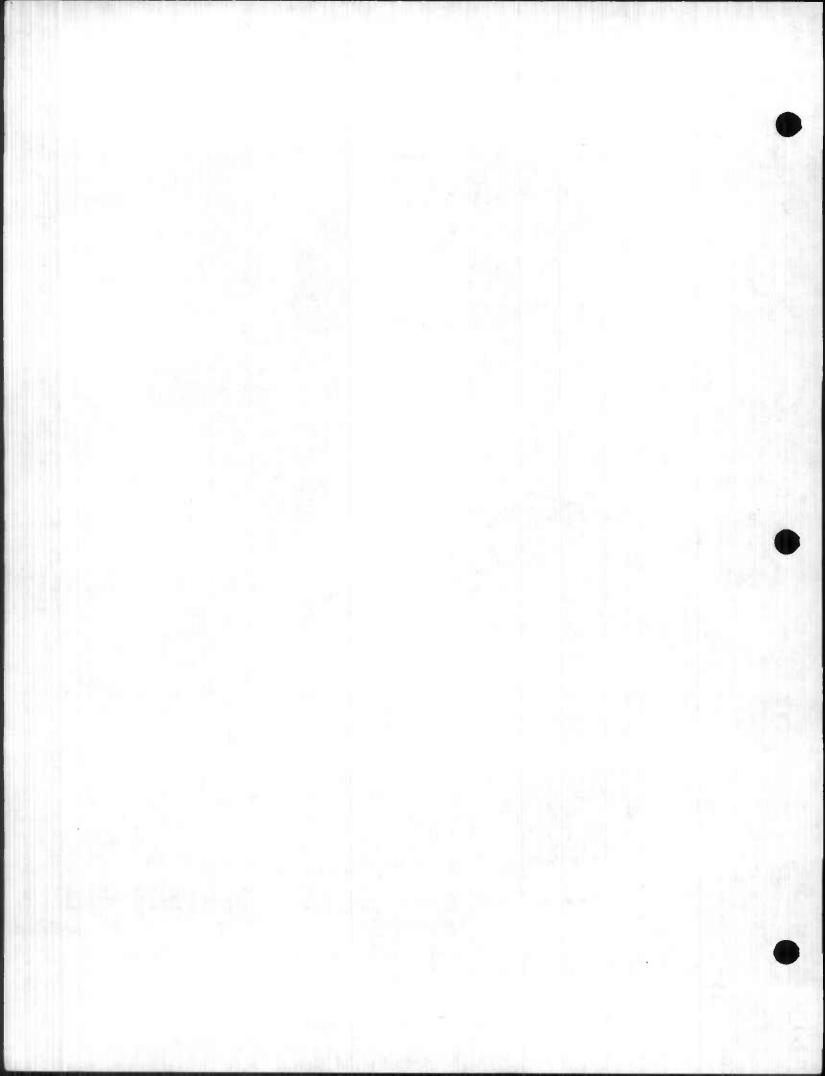
Square Drive Batti More Maryland

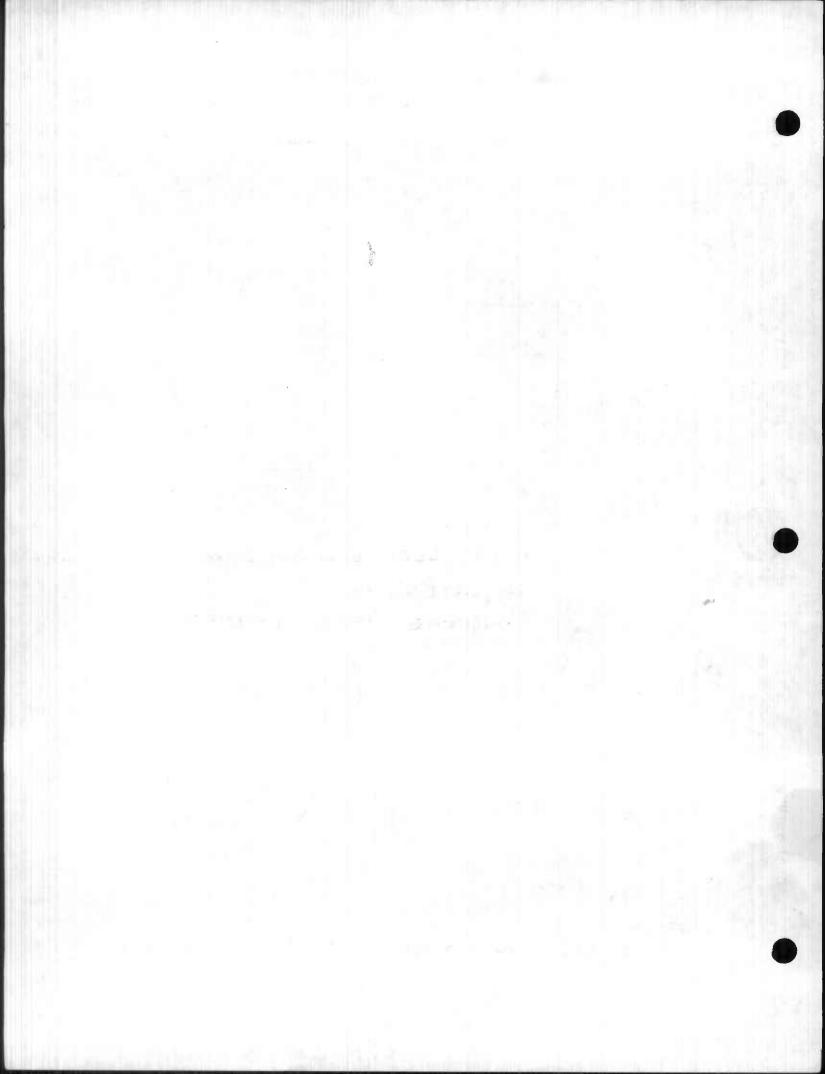
30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)



an	Decedant's Nama (First, Middla, Last)				2. Date of De		3. Tims of Death
cal	Annie Viola Loeloff				Septem	per 13,	2000 9:05 p.m.
ier	4a Facility Name (If not institution, give street and number)				, or Location of Death		
	1111 Hanson Road		thday) If Under 1 Ye	Edgewo	~	Harfo	
	5. Social Security Number  098-14-5196  Usual Residence of Decedent  6. Sex 1 □ M 2 □ ▼ 7. Age	e (In yrs. last bir 91	Yrs. Months Da		Hrs. 8. Date of Bin Min. (Month, Da June 2.	y, Year)	9. Birthplace (State or Foreign Country) North Carolina
	10a. State 10b. County	10c. City, Tow	n or Location	1000			10d. Inside City Limits
	Maryland Baltimore	Middle	River				1 ☐ Yas 2 ☒ No
	10e. Street and Number 615 Wampler Road		10f. Zip Coo 2122			U.S.A.	
	11. Marital Status 12. Was Decedent B	Ever in U.S.			? (Specify Yas or No		e - American Indian,
	1 Never Married 2 Married 1 Yes 2 Married 1 Yes, Give 1 Year or Dates:		If Yes, specify C	Cuban, Mexican, P	uerto Rican, atc.)	Specify	k, White, etc.  White
	15. Decedent's Education (Specify only highest grada completed)	16a.	Decedent's Usual Oc (Give kind of work do	ne during most of	working	16b. Kind of Bu	usiness/Industry
ŀ	Elementary/Secondery (0-12) College (1-4or 5		ine. DO NOT use re	tired)	1140.7	Norso C	'na ao
	8 17. Father's Name (First, Middle, Last)	AS	sempler	18. Mother's	Neme (First, Middle,	Aero S Maiden Sumam	*
	John White			-Wilda	-Plemmos	WILDA P	LEMMONS
	19a. informant's Name/Relationship (Type, Print)	196	. Mailing Address (Str	reet and Number of	or Rural Route Numb	er, City or Town,	State, Zip Code)
	Joyce Browder (daughter		4 Long Bar				
	20a. Mathod of Disposition  → Burial 2 □ Cremation 3 □ Removal from State	cemete	f Disposition (Nama o ry, crematory or other	placa)	Data O / 4 C / 2 C C		City or Town, Stata
	4 Donation 5 Other (Specify)	HOTTA	Hill Mem.				more, Maryland
,		,	1407 016	ruzdzins	ki Funera	l Home,	P.A. Maryland 21221
	23a Pant. Enter the disease, or complications that caused shock, of heart failure. List only one cause on each lin	the death. Do					Approximate Interval Between
Examiner	disease or condition resulting in death)  a. AI3	Due to (or as a	consequence of):	6		76.1	
	If any, leading to immediate causa. Enter Undarlying Cause (Disease or Injury that initiated events	4 Husia	consequence of):	on .			
	that initiated events	Due to (or as a	consequence of):	e given in Part I.	23b. Did	tobacco uss con	ntributa to the causs of death
	Cause Dissease or injury that initiated events resulting in death) Last  d	Due to (or as a	consequence of):	e given in Part I.		tobacco uss cor Yss 2□ No	ntributa to the causs of death
	Cause Dissease or injury that initiated events resulting in death) Last  d	Due to (or as a	consequence of):	e given in Part I.	1 🗆		
	Cause Dissease or injury that initiated events resulting in death) Last  d	Due to (or as a	consequence of):	e given in Part I.	1 🗆	Yss 2 No an autopsy	Probably 4 Unknow  24b. Were autopsy findings available prior to completion of causa
	Part II. Other significant conditions contributing to death but 25. Was case referred to medical examiner?	Due to (or as a	consequence of):	26. Place of	1 □	Yes 2 No an autopsy med?  Yes 2 No	3 Probably 4 Unknow  24b. Were autopsy findings available prior to completion of causa of death?
	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpalie  27. Menner of Death Natural 5 Pending Investigation   Pending Investigation	Due to (or as a culture of the cultu	consequence of):  In the underlying cause  utpatient 3□ DOA  Time of liqury	26. Place of	24a. Was performed to the control of	Yes 2 No an autopsy ormed?  Yes 2 No one) denca 6 Oth how Injury occurr	3 Probably 4 Unknow  24b. Were autopsy findings available prior to completion of causa of death?  1 Yes 2 No  Ner (Specify) assisted red living
	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatie  27. Menner of Death Natural 2 Accident Investigation (Month, Da)	Due to (or as a country year)  2 ER/Out 2 ER/Out 2 28b.	consequence of):  In the underlying cause  utpatient 3□ DOA  Time of Injury	26. Place of Other: 4 □ Nursi Injury at Work? 1 □ Yes 2 □ No	24a. Was performed to the control of	Yes 2 No an autopsy primed?  Yes 2 No one) denca 6 Oth how Injury occur.	24b. Were autopsy findings available prior to completion of causa of death?  1 Yes 2 No
	25. Was case referred to medical examiner?  1	Dua to (or as a country)  out not resulting in the property of	onsequence of):  In the underlying cause  In the underlying cause  In the underlying cause  It patient 3 DOA  Time of larger  M  arm, street, factory, off  e, death occurred et the	26. Place of Other: 4 Nursi Injury at Work? 1 Yes 2 No ice	24a. Was performed to the control of Death (Check only on the control of the cont	Yes 2 No an autopsy rmed?  Yes 2 No one) denca 6 Oth how Injury occur  Street and Numb wn, State)  cause(s) and ma	3 Probably 4 Unknow  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  Per (Specify) assisted ared 11Ving  Per or Rural Route Number,
	25. Was case referred to medical examiner?  1   Yes   2   No   No   No    27. Menner of Death   No   No    28a. Data of Injun (Month, Da)    29a. Certifier   1   Certifying Physician: To the basis of (Check only)   2   Medicat Examiner: On the Check only   2   Medicat Examiner: On the basis of (Check only)   2   Medicat Examiner: On the Check only   2	Dua to (or as a country)  out not resulting in the property of	utpatient 3 DOA Time of Injury M arm, street, factory, off	26. Place of Other: 4 Nursi Injury at Work? 1 Yes 2 No ice	24a. Was performed to the control of Death (Check only on the control of the cont	Yes 2 No an autopsy pred?  Yes 2 No one) denca 6 Oth how Injury occur  Street and Numb wn, State)  cause(s) and ma dete end placa,	3 Probably 4 Unknow  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  Per (Specify) assisted ared 11Ving  Per or Rural Route Number,

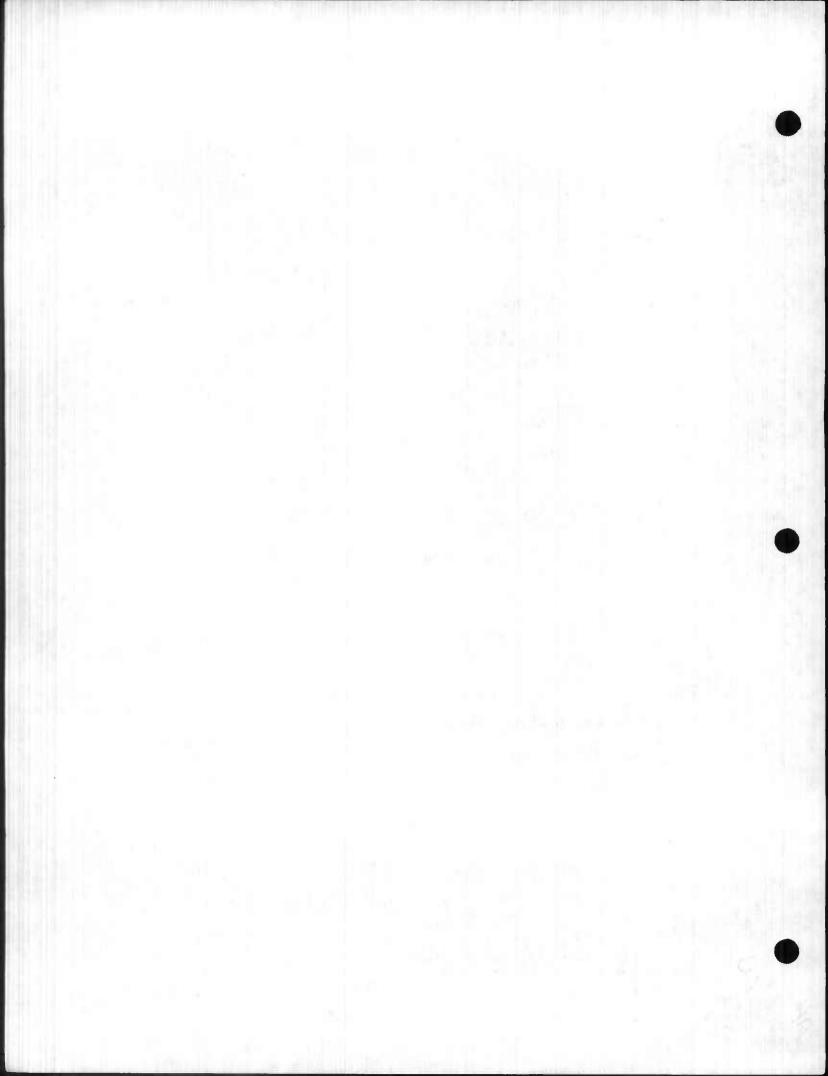
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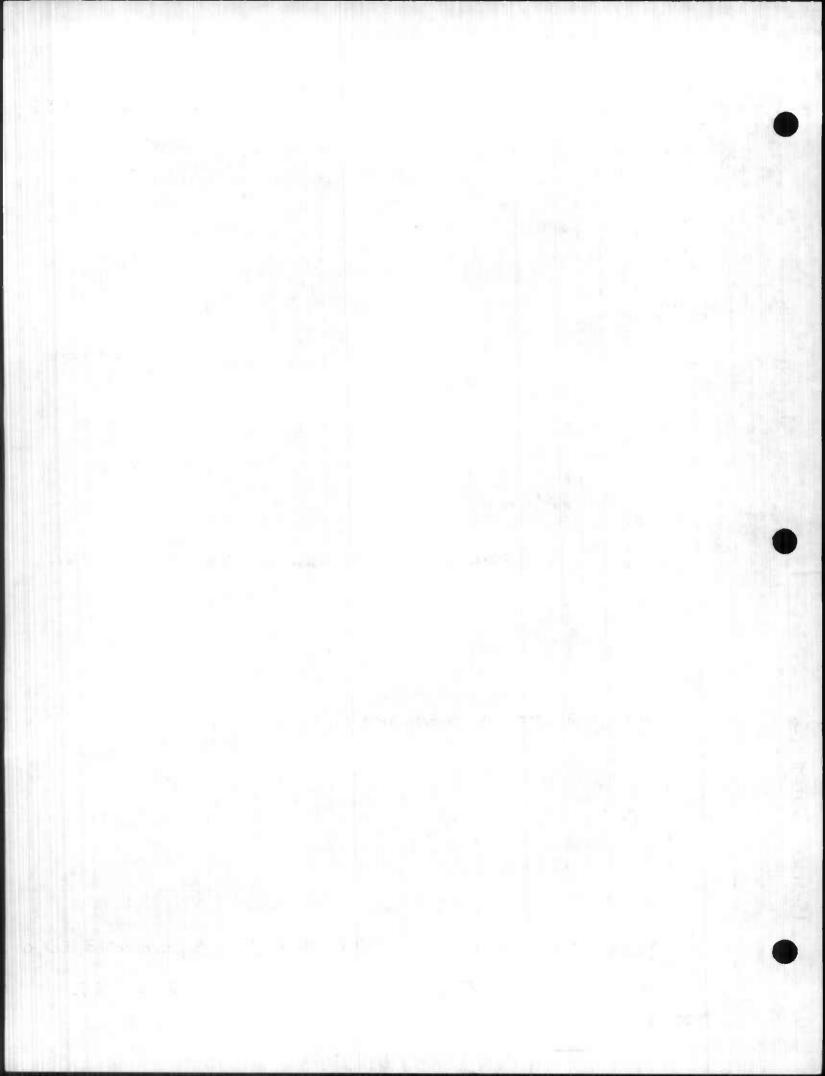
State of Maryland / Department of Health and Mental Hygiene

			C	ertificate of	Death		Reg. No.	10 2	9228
1.11	1. Decedent's Name (First, Middle, L	ast)				2. Dete of D	eath Day	Year 3.	Time of Death
Physician /Medical	Joseph Leo	Mercier				SEPTEME			4:15 PM
Examiner	4a Facility Name (If not institution, g	ive street end number)			4b. City, To	wn, or Location of Dea	th 4c. County	of Death	
	3 VALLEY ARBOR CO	OURT APART	MENT F		ESSEX		BALT	IMORE	
Funeral Director	5. Social Security Number 6. 001 18 4462	Sex 7. Age 1 M 2 □ F	(In yrs. last birthda 74 Yrs.	y) If Under 1 Year Months Days		Min. 8. Dete of Bi (Month, D March	irth 7926	9. Birthplace New Hall	(State or Foreign
2	Usual Residence of Decedent		40- Oh. T.	8				101	
oeam with the Maryland ms 23a or 28a-1 show f.must be notified at neral Director	Maryland Baltimo		10c, City, Town or Esse:	х			into.		Inside City Limit
or 2	10e. Street and Number			10f. Zip Code	0.4		10g. Citizen of 1	What Country?	
23a	3 Valley Arbor Co	· · · · · · · · · · · · · · · · · · ·		212			USA		
	11. Meritel Status	12. Was Decedent E Armed Forces?	ver in U,S.	<ol> <li>Was Decedent of If Yes, specify Cut</li> </ol>	Hispanic Origon, Mexican	gin? (Specify Yes or N , Puerto Rican, etc.)	0- 14. Had Bla	ce - American II ck, White, etc.	idian,
b	1 Never Married 2 Merried 3 Widowed 4 MiDivorced	1 ☐ Yea 2 💆 No If Yes, Give Year or Dates:		1□ Yes 2ŪXNo	Specify:		Specif	White	
et me 2	15. Decedent's I (Specify only highest g	Education rade com <i>pleted)</i>	(Gi	cedent's Usuel Occu we kind of work done	during most	of working	16b. Kind of B	usiness/Industr	У
E . C . D.	Elementary/Secondary (0-12)	College (1-4or 54	life	. DO NOT use retire	ed)				
Hygie of the Co	12		Se	aman	40 14-41-4	de bloome (Fines & Sinfall		ant Mar	ines
S s S	17. Father's Name (First, Middle, Las					r's Name <i>(First, Middle</i> nelia G		ne/	
nd Mental Ind Mental I	Alfred Mercier						regoir		
s 1 and 2 should I Health and Men tem 27 is marke other treumatic TO	19a. Informant's Name/Relationship Michael Mercier					ror Rural Route Number eet Englew			
of Health item 27 r other tr	20a. Method of Disposition	DD	20b. Placa of Dis	position (Name of rematory or other pla	ace)	Date	20c. Location	- City or Town,	State
Page nent o	1 Burial 2 Tremation 3 4 Donation 5 Other (Spec		Greenmou	nt Cremat	ory 9/	15/2000	Baltimo	ore, Ma	ryland
Department of Himportant of Himportant in the	21. Signature of Fungral Service Lice	M086	ral Home F						
	1/2-120	~							
certificate be assecuted ding physician and use as the burial-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evente resulting in death) Last	c	Oue to (or as a cons	equenca of):					
The law requires that the death certific tale has been signed by the attending p page 2 should be detached for use as:  Completed by Physician/Mex		l d							
the atter the offer of siciar	Part II. Other eignificant conditions			underlying cause g	iven in Part I	23b. Did	d tobacco use co	entribute to the	cause of deat
ed by detac	Chronic Oh-to	richine Pula	nanacu			10	Yee 2□ No	3 Probabl	y 4 Unkno
signed d be de	Chronic Obstr	active	Toning 9			24- 144-		24h Wara	autopsy findings
been sign should be	Chronic Alcoh	olism				per	s an autopsy formed?	evailab	ole prior to etion of cause
has by ye 2 s						parti	ia(	of deal	h?
page Com						1/3	Yes 2□No	1 [2] Ye	es 2 No
this certificate ral director, pag	25. Was case referred to medical examiner?	December 1		10		of Death (Check only	one)		
T dis	XXYes 2 No		t 2 ER/Outpat	ient 3LI DOA		rsing Home 5 Res			CENE
After fune	27. Manner of Death  1 Matural 5 Pending 2 Accident Investigati		Year) 28b. Time Injury	/ Wo	ury at ork? ]Yes 2 □		how injury occur	rred	
after de Directo d in by th	3 Suicide 6 Could not determine		ry - At home, farm, (Specify)	street, fectory, office	1		(Street and Num. own, State)	ber or Rural Ro	ute Number,
Hospi Houner Tely fil	29e. Certifier 1 Certifying P (Check only one) Check only one)	thysician: To the best of aminer: On the basis of and manner state	examination and/or	ath occurred at the tinvestigation, in my	ime, date an oplnion, dea	d place, and due to the	e cause(s) and m o, date and place,	anner es state and due to the	d. cause(s)
within 2 To the comple	29b. Signature and title of certifier	and the state of t		29c. Licer	ise number		29d. Date signe	ed (Month, Day	, Year)
-3+8	Derum	2 Chuten	2		O.C.M	.E.	SEPTEMBE	R 12,	2000
10	1 1 1	completed cause of de							
	Dennis J. C	hutemo		III Penn S	Street	, Baltimor	e, Maryl	and 212	201
State Registrar	SEP 1. 5 20	32. Registra	r's Signeture	Spark	1/3				
and the second				-					

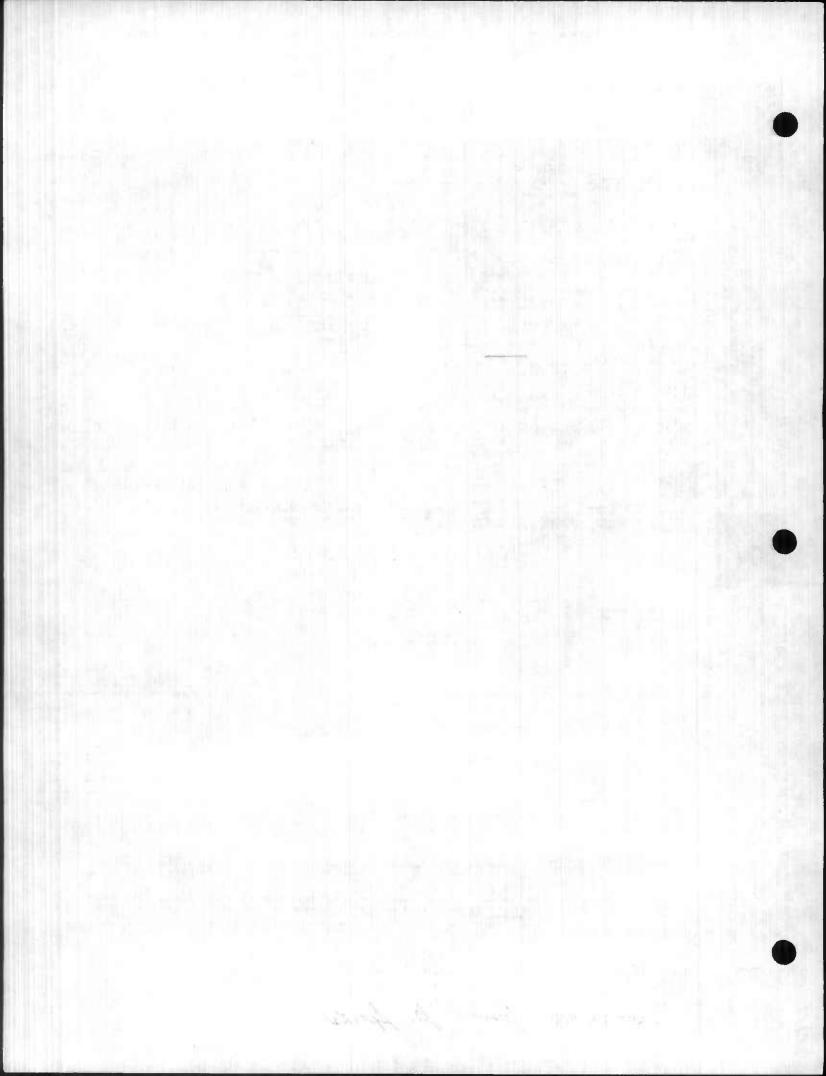


12	Date of Death		3. Time of Des	0.1
Certificate of Death	Reg. No.			
State of Maryland / Department of Health and Mer	ntal Hygiene	00	29220	7
ypo or raint in Black machine min 7.00aio 7m a	opioo mio E	9.210.		

			OUTUI	icate of	Death		Heg. No.		
Physician /Medical	1. Decedent's Name (First, Middle, Last)  Dorothy C. Merke					2. Date of Dec		Year 00 17:	Death 35
Examiner	4a Facility Name (If not institution, give				4b. City, Town, or L	ocation of Death	4c. County	of Death	
	210 Lavern Avenue				Baltimore		Balti	more	
Funeral	5. Social Security Number 6. Sec	7. Age (In yrs.		Under 1 Year lonths Days	If Under 24 Hrs.	8. Date of Birt (Month, Da	th V Veer)	9. Birthplace (State or	Foreign
Director	216-03-4927	M 200 F 93	Yrs.	ionins Days	Hours Min.	August		9. Birthplace (State or Country) Maryland	
9	Usual Residence of Decedent								
a dat	10a. State 10b. County	10c. Cit	ty, Town or Locati	ion				10d. Inside City	
notifier recto	Maryland Baltimore	Ba:	ltimore					1 ☐ Yes	S.M. No
or 18a-t	10e. Street end Number			10f. Zlp Code		37 67	10g. Citizen of \	What Country?	
	210 Lavern Avenue		- 880	21227			Unit	ed States	
iner must	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was	Decedent of	Hispanic Origin? (Sp ban, Mexican, Puert	pecify Yes or No	- 14. Rac	ce - American Indian, ck, White, etc.	100
-	1 Never Married 2 Married	1 ☐ Yes 2 ☒ No If Yes, Give		Yea 2√2 No			Specify		
dby	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:							
Completed	15. Decedent's Edu (Specify only highest grade		16a. Decedent	d of work done	during most of work	king	16b. Kind of B	usiness/Industry	
2 E	Elementary/Secondary (0-12)	College (1-4or 5+)		NOT use retire					
	12	4	Deni	tal Ass		o Wheel State		h Profession	n
Be s	17. Father's Name (First, Middle, Last)				18. Mother's Nam			ne)	
To To					1	Brodie			
	19a. Informant's Name/Relationship (Ty	pe, Print)			t and Number or Ru				
, i	Bruce Merkel-Son				venue, Ba				
or othe	20a. Method of Disposition  12 Burial 2 Cremation 3 R		Place of Disposition cometery, cremate	on (Name of ory or other pla	ace)	Date	20c. Location -	City or Town, State	
6	4 ☐ Donation 5 ☐ Other (Specify)		idon Parl	k Cemete	ry 9	-16-00	Baltimo	re, Marylan	d
to de	21. Signature of Purieral Service License	81		ame and Addr	ess of Facility				
558	X USA S HEB	person	Lou	idon Pa	rk Funera	1 Home	imana l	Maryland 21	220
	23a. Part1. Enter the disease, or corbolishock, or heart failure. List only or	cations that caused the deat	th. Do not enter to	he mode of dy	ing, such as cardiac	or respiratory a	rrest,	Approximate Interval Betw	
ysician	SHOCK, OF HEART FAILURE. LIST ONLY OF	e cause on each line.						Onset and De	eath
Medical	Immediate Cause (Final disease or condition	Atherosch	a volte	Cardin	and and in	rdic.	c.c.a.	Veze	7
aminer	resulting In death)		or as a consequer		NWIW (U	urki	410	1001	٥.
je je	BELLEVILLE TO		Here's county						
buriel-transit	Sequentially list conditions.	Due to (c	or as a consequer	nce of):	1111				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events							C. C. Contract	
s the bu	that Initiated events resulting in death) Last	Due to (d	or as a consequen	ice of):					
use as t	Tosuming in death / Last								
an/M									
hed for	Part II. Other eignificent conditions con	tributing to death but not res	sulting in the unde	rlying cause g	iven in Part I.	23b. Did	tobacco uae co	entribute to the cause of	death?
The state of						10	Yee 2□ No	3 Probably 4	Inknown
be de by F	Chronic obstruc	the holmon	1011 mon	rast		P. Contract			
should b						24a. Was	an autopsy	24b. Were autopsy tir evailable prior to	
2 she						p.Sire		completion of ca of death?	use
page 2						10	Yes 2XNo	1 Yes 2 1	No
Setor, pa	25. Was case referred to medical				26. Place of Dea				
3.5	everniner?	lospital: 1  Inpatient 2	ER/Outpatient	3 DOA O	ther	ome 5 ☐ Resi		ner (Specify)	
eral dire	27. Manner of Death		28b. Tima of	28c. Inju			how injury occur		
death. stor: After / the fune  Cation	Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury		ork? ∃Yes 2⊟No				
y the	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome farm street			28f. Location (	Street and Numi	ber or Rural Route Numb	90°,
in by	4 Homicide determined	building, etc. (Special	<i>fy)</i>	,,,		City or To	wn, State)		3
be Funeral Director: Affect pletely filled in by the funeral edical Certification;	29a. Certifier 1 Certifying Phys	sician: To the best of my kno	owledge death on	curred at the t	ime, date and place	and due to the	cause(s) and m	anner as stated	
To the Funeral Discompletely filled II	(Check only one)	ner: On the basis of examina and manner stated.	ation and/or invest	tigation, in my	opinion, death occu	rred at the time,	date and place,	and due to the cause(s)	
Me	29b. Signature and title of certifier			29c. Licen	ise number		29d. Date signe	ed (Month, Day, Year)	
ŏ	dana Man	no M.D.		98	-0139	1	Sontam	ber 13, 20	200
,					0.31		١٠١١١١١١١١١١١١١١١١١١١١١١١١١١١١١١١١١١١١١	-, -	
/	30. Name and address of person who co	mpleted cause of death (Iter	m 23a) (Type, Prir	nt)	7		007	7 10 0 0	
J	24011011121	n 700	Cutor	DUC	Balt	more	IND C	1269.	
State	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	/					

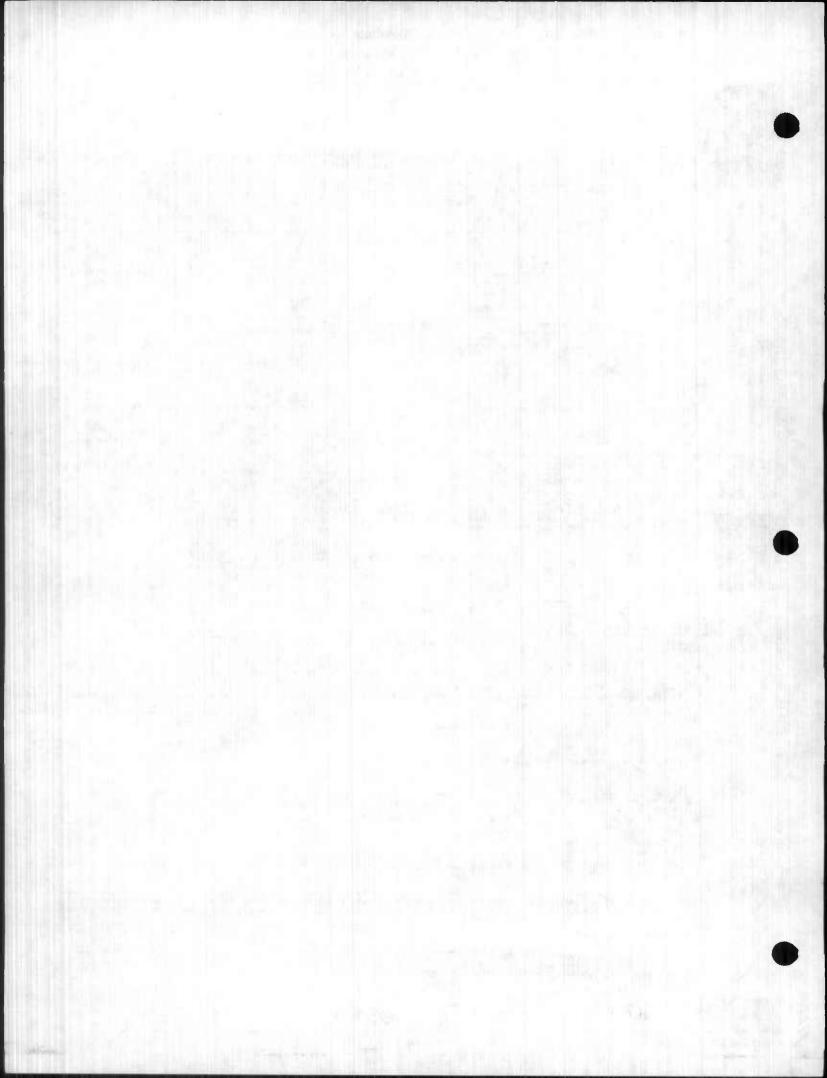


amended item #	15 per fh g787 9/15/00 a			nent of Health icate of Death		Reg. No.	0 29230
Physician /Medical	1. Decedent's Name (First, Middle, Last		INLEY		2. Date of D Month SEP	Day TEMSERS,	Year 2000 SPM
Examiner	4a Facility Name (If not institution, give				own, or Location of Des	th 4c. County	of Death
	NORTHWEST HOSPI			Under 1 Year   If Under			N/A
Funeral Director	09M-20-2604	7. Age (In)		Under 1 Yeer If Under onths Days Hours	Min. 8. Date of B	Sey, Year)	Birthplace (Stelle or Foreign Country)     MO
pu M	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Location	on			10d. Inside City Limits
the Marylar 28a-f show notified	MO BALTIMO	RE RI	ANDAUST	DUN			1 □ Yes 28 No
or 284	10e. Street and Number			Of. Zip Code		10g. Citizen of V	/hat Country?
death with the Manyland ms 23s or 28s-f show count be nothed at charal Director	3701 TWIN LAKES	CT. APT	. 317	21244		USA	7
5 2 5	11. Menital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Wes Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		Decedent of Hispenic On s, specify Cuban, Mexico Yes 2 No Specify		14. Raci Blec Specify	a - American Indian, k, White, etc.
21215-0020 d within 72 hours at giene. The construction of the con	15. Decedent's Edu	Year or Dates:	16a Decedent	s Usuel Occupation		16b. Kind of Bu	siness/Industry
1 21215-0 led within 72 ho lygiena. her then "naturn it, it is a completed	(Specify only highest grad	e completed)	(Give kind	of work done during mos NOT use retired)	st of working		
d with	12 TH GRADE	College (1-4or 5+)	rs. SCHOO	L TEACHER		BALTIM	IORE CITY
Baltimore, Maryland 212: permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiena. Important: If Itam 27 is marked other than any injury or other traumatic avent, tre- more.  To Be Comp	17. Father's Name (First, Middle, Last)				er's Name (First, Middle		9)
faryla 2 should be and Meni is marked sumatics	JOHN FRAZIER				AN MCAB		
Mar 12 sh h and la m resum	19e. Informent's Name/Retationship (T)						Stele, Zip Code) 21133
e, N 1 and 1 and Health Mm 27 ther tr	CHARLES FRAZIER 20a. Method of Disposition	SON	b. Place of Disposition	UIN LAKES	CT. #317,	KANDAU	City or Town, State
Pages vent of the rry or of	1 ☑ Burial 2 ☐ Cremation 3 ☐ F	emoval from State	cemetery, cremato	ry or other place)		1000	A STATE OF THE STA
Baltimore, Nomit. Pages 1 and Department of Health Important: If Itam 27 any injury or other trans.	4 Donation 5 Other (Specify)  21. Signature of Funger Service Licens		JEW CATHE		9-18-00	BALTO.	
Balt. Permit. Departri	Wang C	<b>H</b>	515		L' PIKE B	AUTO, MD	
	23a. Part1. Enfor the disease, or compleshock, or heart failure. List only or	cations that ceused the cause on each line.	death. Do not enter th	e mode of dying, such as	s cerdiac or respiratory	arrest,	Approximate Intervel Between Onset end Death
Physician // // // // // // // // // // // // //	Immediate Cause (Final	TALE	01 0	1 = 1 0 M	115.1	0011	
Examiner	disease or condition resulting in death)			REBRAL	- Ite M	ORKAN	48
Parametria P		Due t	to (or as a consequen	ce of):			
60, be executed ician and bunal-transit	Sequentially list conditions,	Due t	o (or as a consequen	ce of):			1
ian ar	if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury						
58760, icate be exphysician is the burial	that initiated events resulting in death) Last	Due to	o (or as a consequen	ce of):			
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Box ( Both certif attending for use as							
P.O. that the de ad by the a detached to Physic	Part II. Other significant conditions cor	tributing to death but not	resulting in the under	lying ceuse given in Part			ntributa to the cause of death?
IS, P. es that the igned by be detacted by Ph.						」Yas 2∟No	3 Probably 4 Unknown
cord requir been s should					24a. Wa	as an autopsy formed?	24b. Were autopsy tindings available prior to completion of cause of death?
Re lay be	I No SY IS A C				10	Yes 22 No	1 ☐ Yes 2 ☐ No
	25. Was case referred to medical			28. Plac	ce of Death (Check only		
of Vital Representations and Physicians The Lentificate hard director, page and director, page 1. To Be Com.;	exeminer?	lospital:	2 ER/Outpatient	Other:	lursing Home 5 Re		ar (Specify)
0 5 5 5	27. Manner of Death  1 Naturat 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Dey Yea.	r) 28b. Time of Injury	28c. Injury at Work?  M 1 Yes 2		e how injury occur	red
Division of Attended in by the Certifical	3 Suicide 6 Could not be determined	28e. Ptace of tnjury - / building, etc. (Sp	At home, farm, street, ecify)	factory, office	281. Location City or 7	(Street end Numb own, Stete)	er or Rural Route Number,
Division C To the Hospital or Attending P within 24 hours after death completely filled in by the funera Medical Certification:				curred et the time, dete a gation, in my opinion, de			
To the within To the comple	29b. Signature and title of certifier	A .	,	29c. License number			d (Month, Day, Year)
		/ um	Los	937	333	SEPTEM	GER 12, 2000
3	30. Name and address of person who co	empleted ceuse of death (	(Item 23a) (Type, Prin	ALTO M	0211		
State	31. Dete filed (Month, Day, Year)	32 Registrer's S	ignature &	1			
Registrar	SFP 1 5 2000	Denne	N. 4	outs.			



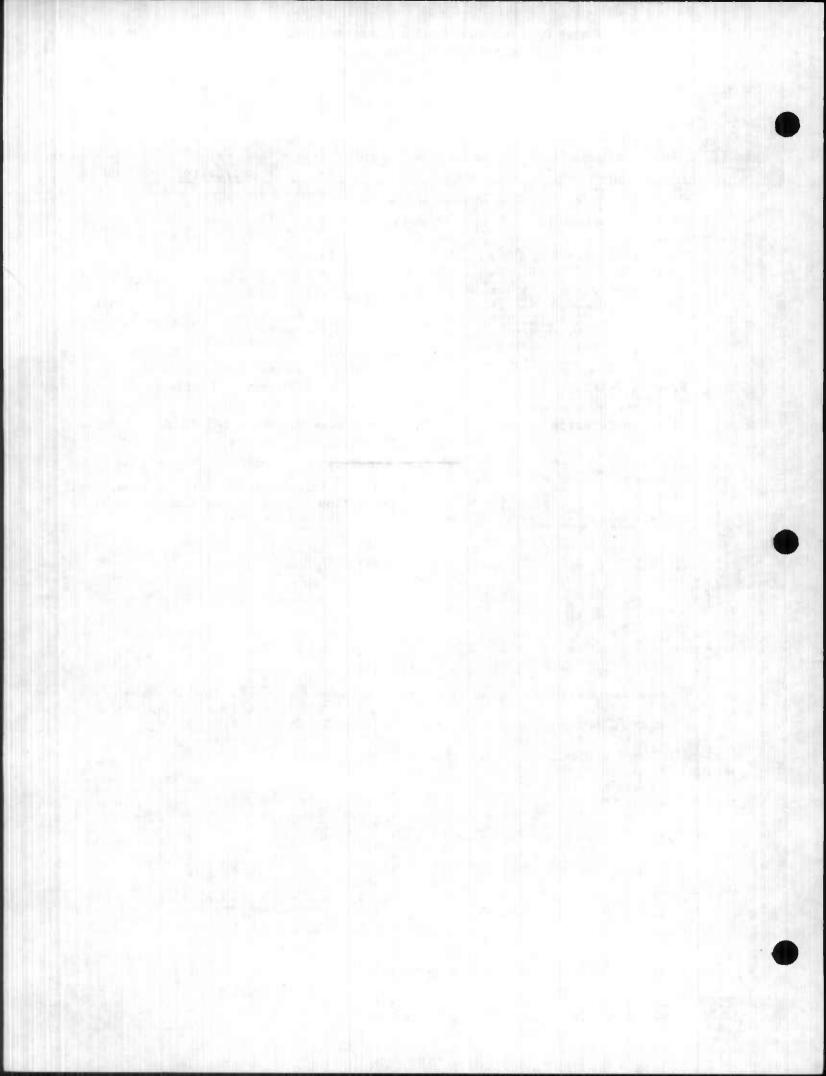
tate of Maryland / Department of Health and Mental Hygiene	a no	29231
Certificate of Death Reg. No.		2 2 2 2 1

				Certifica	te of Death	R	eg. No.	29231
		1. Decedent's Name (First, Middle, Las	18)			2. Date of Deal Month	lh Day Ye	3. Tima of Death
	Physician /Medical	Jane Ann	Phillips			Sestan	1- 0	950A
	Examiner	4a Facility Name (If not institution, give			4b. City, Town, or	Location of Deeth	4c. County of E	
		Stella Maris @	Mercy		Balt	imore		N/A
	Funeral	5. Social Security Number 6. Se		last birthday) If Und	or 1 Yeer If Under 24 Hr. Deys Hours Mir		Year) 9.	Birthptace (State or Foreign Country)
	Director	215-18-5570	□M 200 F 78	Yrs.	Deys Tiodis IVIII	Feb. 6.	1922	Maryland
	p.	Usual Residence of Decedent	10- 05	To an anti-onti-on				
	aryla ahov ahov	10a. Stete 10b. County		y, Town or Location				10d. finside City Limits 1 ☐ Yes 2 No
	ter death with the Marylar Herre 23a or 28e-f show the must be notified at Funeral Director		Etimore	Rosed				
	Olre	10e. Street and Number		101. Z	p Code	1	0g. Citizen of Wha	t Country?
	r Herre 23a The must Funeral	1315 Chesaco Aven			21237		u. s.	
	te de	11. Merital Stetus	12. Wes Decedent Ever in U, Armed Forces?	S. 13. Was Dec If Yes, sp	edent of Hispanic Origin? ( ecify Cuben, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		American Indian, White, etc.
20	urs aft.	1 ☐ Never Married 2 ☒ Merried 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No	1 ☐ Yes	2 No Specify:		Specify:	
8	hour hour	15. Decedent's Ed	Year or Dates:	16a. Decedent's Us	ual Cocupation		16b. Kind of Busine	White
215-0020	filed within 72 hours after death with the Maryland Hygiene. Hygiene than "natural", or items 23a or 28a-f show mit, the tender Exercises must be notified as the Completed by Funeral Director.	(Specify only highest grad	de completed)	(Give kind of w	ork done during most of we use retired)	orking	TOD. KING OF DUSIN	osariidustiy
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	De Taring	17. Father's Neme (First, Middle, Last)		TACE CA		me (First, Middle, i		ruet Louge
lan	Mental Harked out	Percy L. Reynold	s. Sr.		Mildre	d G. Haze	elwood	
Maryland	2 should and Men le marke aumatic	19a. Informant's Name/Relationship (7	lural Route Number		te, Zip Code)			
Z	27 Te	Edward Phillips, .	Sr. (Husband)	1315 Ches	aco Ave., Ap	t 328 Bo	altimore.	Md. 21237
re,	s 1 and I Heelth tem 27 other tr	20a. Method of Disposition	20b. P	lace of Disposition (Nemetery, crematory or	me of		20c. Location - City	
9	Peges net of i mt: if its iry or o	1 X Burial 2 Cremation 3 4 Donation 5 Other (Specify	Hemovel from State		aith	0/15/00	Raltimon	Manuland
Baltimore,		21. Signature of Funeral Service Licen		22 Name I	nd Address of Facility			e, margrana
B	Departi Departi Importu any Inju	Malot 2		Schur	unek Funeral			1 04040
		1	plications that caused the death		Brehms Lane,			Approximate
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	Physician /Medical	Immediate Cause (Finet	M	1.4.40	c Brenst	1		
	Examiner	disease or condition resulting in death)				Lurie.		1
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,	is death certificate be executed the attending physician and hed for use as the bunk-transit ysician/Medical Examin	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	r as a consequence of	).			
68760,	physicia s the bur edical	Cause (Disease or injury thet initieted events	C. Due to for	r as a consequence of				
68	ficat pphy as the	resulting in death) Last	Due to (or	as a consequence of				
Вох	ndin use use	de la casa de la casa	d					1
	d for	Part II. Other significant conditions of	potributing to death but not resu	ulting in the underlying	cause given in Part I	23b. Did to	obecco use contril	buts to the cause of death?
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	es that igned i be det be det							
Records,	or or or or or or or or or or or or or o					24a. Was a		4b. Were autopsy findings available prior to
00	> 10 00 ==					perfor	med !	completion of cause of death?
	The law require sate has been signed as should Completed					10Y	es 22 No	1 Yes 2 No
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	rthis eral di	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. tnjury at Work?	_	ow injury occurred	openity) - pli to
0	th. Afte	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
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ă	tal or Attending P rs after death. al Director: After t led in by the funer Certification:	4 Homicide	building, etc. (Specify	()		City or Tow	n, State)	
			ysician: To the best of my know					
	thin 24 hours thin 24 hours the Fune impletely fil	(Check only 2 Medicat Exam	iner: On the basis of examinat and manner stated.	tion and/or investigation	n, in my opinion, death occ	curred at the time, o	late and place, and	due to the cause(s)
	Within To the comp	29b. Signature and title of certifier		2	9c. License number		29d. Date signed (A	
		I De The	J m		D4082	1	9113	2000
	0)	30. Name and address of person who	completed cause of death (Item	23a) (Type, Print)				
		1 1 17	useber 301	St Pul	PI Bulding	r MD	21202	
	State	31. Dete filed (Menth, Day, Year)	3. Registrar's Signal		els			
	Registrar	25L T 2 7000		100	403			



State of Maryland / Department of Health and Mental Hygiene 00 29232

			AMEND#20B per F.H.	G787 9-15-	-2000 J	AB Ce	ertificat	e of	Death			Reg. No.	, 0	67676
			1. Decedent's Name (First, Middle	, Last)	HE					1.40	2. Date of De		Van	3. Tima of Death
	Physicia		LEO				PETERS	ON			Month SEPTEMB	ER 12	Year 2000	11:06 PM
	/Medic Examin		4a Facility Name (If not institution	give street and nu	mber)			_	4b. City, To		cation of Death			11.00
	EAGIIIII		THE JOHNS HO	PKINS HOS	PITAL				BALT	IMORI	E			
	Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birthday	) If Under	1 Year Devs	If Under Hours	24 Hrs. Min.	8. Dete of Bir (Month, Da	th Year)	9. Birthpi	lace (State or Foreign try)
	Director		215-18-3582	1 <b>X</b> M 2□ F	79	Yrs.	MONTHS	Deys	Hours	NOW L.	07/04/	1921	MD	)
4	9		Usual Residence of Decedent											
	rylar		10a. State 10b. County		100	. City, Town or I	ocation						10	Od. Inside City Limits
	W III	cto	MD Balti	more		Dunda1	k							1 ☐ Yas 2 K No
	or 28	Oire	10e. Street and Number				10f. Zip					10g. Citizen of	What Coun	try?
	urs after death with the Marylar alt, or Nems 23a or 28a-f show Examiner must be notified	Funeral Director	7008 Mornington RD APT A 21222								USA			
	des F	Jue	11. Marital Status	12. Was Dec	edent Ever	in U,S. 13	Was Dece	dent of H	lispanic Ori an, Mexicei	igin? (Spi	ecify Yes or No Rican, etc.)	- 14. Rad Bla	ce - America	
02	or h	F	1 Never Married 2 Marri	If Yes. Gr	2 No		1□ Yes		Specify:			Specif	V: T.T.	
21215-0020	72 hours after death with the Maryland "natural", or Nema 23a or 28a-f show after Esanthe mest be notified at	d by	3 Widowed 4 Divorced	Year or D	ates:								WILL	
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	77 50 5		17. Fathar's Name (First, Middle, I	actl	-	11	uck D	TIVE		er's Name	/First Middle	, Maiden Suman		ompany
and	S E S	Be	Fred E. Peterso						10.10011	Hann		verley	10)	
3	should by and Menta marked umatic av	10				406 14-2	the Address	/64-004				er, City or Town.	Ctate 7in	Codol
Maryland	A 40 W M		19a. Informant's Name/Relationsh Ella Mae Peters									timore,		
	of Heelth Item 27 other tr		20a. Method of Disposition	on wite	20	Ob. Place of Dist			OII KI	MI	Date	20c. Location		
Baltimore,			1 Burial 2 Cremation		Charles	. cemetery, cri	ematory or o	ther plai						, otato
tim	ther tant		4 □ Donation 5 □ Other (Sp		1	DARALTO W					9/15	Laurel,		
Bal	permit. Page Department of Important: If i any Injury or page.		21. Signature of Funeral Service I	Densee	11/		32. Name ar Bradle	y As	shton	Matt	hews F	uneral H	lome,	Inc.
_	40549		16 know	Lodge	20							ltimore	, MD 2	21222
			23a. Part1. Enter the disease for shock, or heart feilure. Vist	complications that conly one cause on e	eused the each lina.	deeth. Do not e	nter the mod	le of dylr	ng, such as	cardiac	or respiratory a	rrest,		Approximate Intervai Between
	Physician				_	- 11								Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition	A	SPACE	& with	mert	isyst	en D	-AAN	failur	2	- 1	ove day
	LAGIIIII	-	resulting in death)		Due	to (or as a cons		1		1			š	
	p is	Examiner		b	TNEW	novia							i	ove week
-	artificate be executed ing physician and e as the burial-transit	хап	Sequentially list conditions,		Due	to (or as a consi	equence of):							
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68760,	certificate be oding physicia use as the bur	edical	that initiated events resulting in death) Last		Due	to (or as a conse	equence of):							
	oding p	2		d										
Box	death co	lan												
	the de	Completed by Physician/	Part II. Other aignificant condition	ns contributing to d	eath but no	t resulting in the	underlying o	euse giv	ren In Part	i.	23b. Did	tobacco uas co		the cause of death?
P.0		4	CORONARY DATE	Au Disens	P.	Hea	nt Fa	lup	e		10	Yea 2 No	3 Prot	bebly 4 Unknown
Records,	sign d be	by									Ode Wee		Tash W	ere autopsy findings
0	neen hou	etec	RANA Failur	_							perfe	an autopsy ormed?	ava	ailable prior to
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	E # 8		Felty's CayN	Rome						V. 1	10	Yas 28 No	10	Yas 2000
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medicel examiner?	Manakat				04		a of Deat	h (Check only	one)		
5	this of the all dir	2	1 Yes 2 No		-	2 ER/Outpati			4 LI N	ursing Ho		idence 6 DOtt		y)
Division of		Certification:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending		of Injury th, Day Yea	28b. Time tnjury		28c. Injui		100	28d. Describe	how injury occu	rred	
sio	the the	cat	2 Accident Investig	ot be			M		Yes 2	No	ont to a contract	(0.10		10
<u>≥</u>	or Attendent siter deat Director:	틭	4 Homicide determi	ned 200. Place	of Injury - ng, etc. (St	At home, farm, s pecify)	treet, factor	y, office			City or To	wn, State)	per or mura	I Route Number,
	le de la la la la la la la la la la la la la		1											
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only 2 Medical E	Physician: To the Examinar: On the b	asis of exar	knowledge, dea mination and/or l	ith occurred nvestigation	at the ti	me, date ar pinion, des	nd place, ath occur	and due to the ed at the time,	cause(s) and m date and place,	anner as si and dua to	tated. o the cause(s)
	within 2 To the complet	Med	one) 29b. Signature and title of certifier	and man	ner steted.		20	n Linone	se number			29d. Date signe	ed (Month	Day Year)
	5 × 5 0		250. Signature and title of certifier	II A			29				- 1	C /	)	-uj, rodij
	6		Albert Un	g MD				RE	5 000	)		replem	PEU!	2,2000
	7		30. Name and address of person v		e of death	(Item 23a) (Type	Print)	11	1		10 -1	811.		
			31. Data tiled (Month Day, Year)	a MD 3	egistrer's S	HOPENE	104	tal	600	N. W	lfest	MITIM	DE N	1201203
	Sta	te	SEP I 5 2000	Sere	Paral AL2 S	19	bour	1						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day September 12 2000 21:00 Dona 1d Richard Pfarr 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Greater Baltimore Medical Center Baltimore If Undar 1 Yaar Birthplaca (State or Foreign Country) 5. Social Sacurity Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1XM 2□ F Months Days Hours Min Yrs. 70 Aug. 25, 1930 214-26-1712 IN Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No MD Baltimore Phoenix 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? 3833 Blenheim Road 21131 USA 12. Was Decedant Evar In U,S. Amed Forces? 1 △ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Vice President of Williams &
Wilkens 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Publishing 4 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Walter Leo Pfarr Ferndale Mildred Marie Weis 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marlene T. Pfarr/ Wife 3833 Blenheim Road Phoenix, MD 21131 20b. Place of Disposition (Name of cemetey, crematory or other place)
Baltimore Washington
Crematory Sept. 14 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 2000 4 ☐ Donation 5 ☐ Other (Specify) Laurel, MD 22. Nama and Addrass of Facility
Lemmon Funeral Home of Dulaney Valley, Inc. 21. Signature of Funaral Se Michael j. Flagle 10 W. Padonia Road Timonium, MD 21093 Part 1. Enter the disease, or complications that caused tha daath. Do not enter tha mode of dying, such as cardlac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onsat and Daath tmmediate Cause (Final disease or condition resulting in death) a. Multiorgan Failure Days Due to (or as a consequenca of): Progressive Fibrotic Lung Disease Weeks Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of) 23b. Did tobacco use contribute to the ceuse of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy complation of cause of death? 1 Yes 2 □ No 1 N Yes 2 No 25. Was case refarred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

P.O. Box 68760 Records, Division of Vital or Attending Physician: efter death. Director: After this certific

death certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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"natural", or items 23s or adical Examiner must be

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Physician /Medical

Examiner

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Certification:

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Pages 1 and 2 should be filed within 72 hours effer death nent of Health end Mental Hygiene.
nt: if item 27 is marked other then "natural," or items 23.

PFarr, Donald

Director

Funerai

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Completed

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To the I within 2 To the I

24 hours

State Registrar

Nathan A. Dunsmore, Y 1 5

29a, Certifier

(Check only one)

29b. Signature and title of cartifier

MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

Greater Baltimore Medical Center

1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner so stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29c. License number

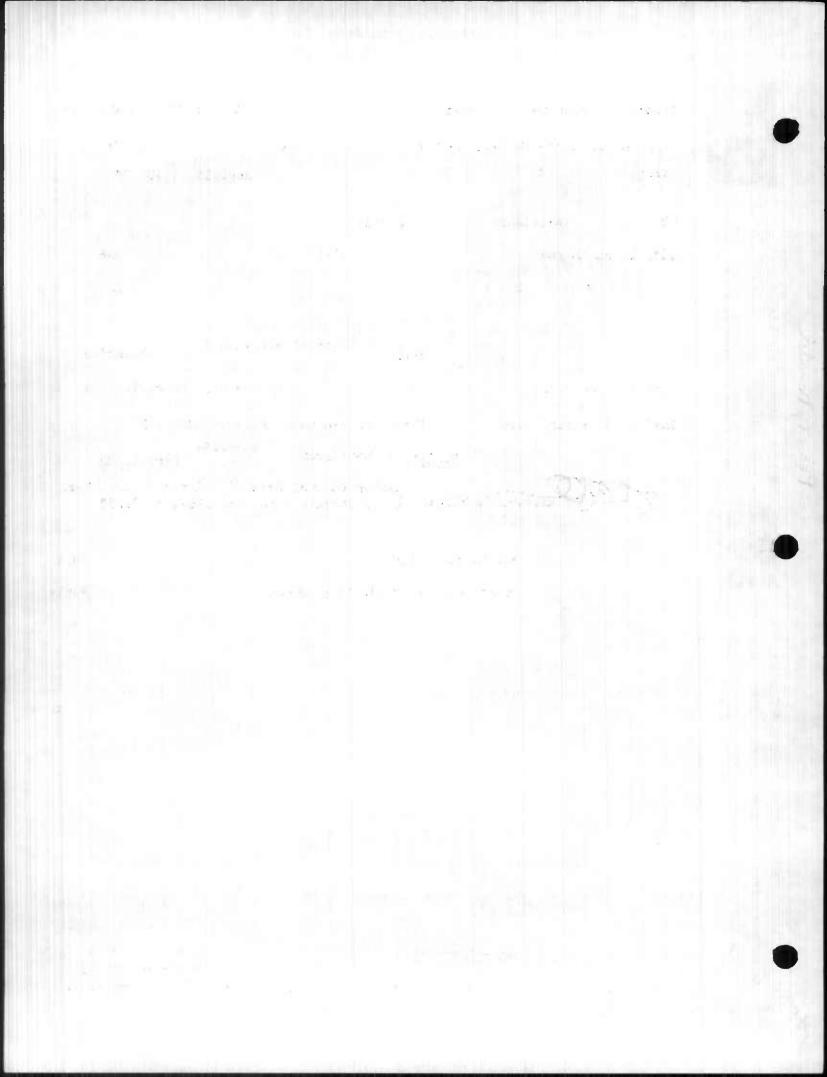
D43003

29d. Date signed (Month, Day, Year)

Baltimore, MD 21204

6701 N. Charles St.

September 13, 2000



9112100

F	Physician
	/Medical
	Examiner

**Funeral** Director

important: if tem 27 is marked other than "natural", or fisma 23s or 28s-f show any Injury or other treumstic event, tre Mexical Exercises must be notified at abotics.

12:00 a.m.

SEPTEMBER 11, 2000

Baltimore, Maryland 21215-0020 Physician /Medical

Examiner

ed by the attending physician and detached for use as the bunal-trans

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires within 24 hours after death.
To the Perseal Director: After this certificate has been sign completely filled in by the tunetal director, page 2 should be completely filled in by the tunetal director, page 2 should be

ADELAIDE PIEPER

	Decedent's Name (First, Middle, Last)  2. Dete of Deeth  About  3. Time of Death												of Death
	Adelaide U. Pieper Sept. 11 2000 12:00 AM												MA (
ŀ	4a Facility Name (If not institution, give street and number)  4b. City, Town, or												
	Stella Maris Hospice						Timo	nium	1	Baltimore			
	5. Social Security Number 6. S	7. Age (In yrs.	last birthday) If Under 1 Yes			Timoniun  If Under 24 Hrs.		8 Dete of Bir	th		place (State	or Foreign	
ı		IDM 2DE		Vre		Days	Hours	Min.	(Month, Day	y, Year)	Birthplace (State or Foreign Country)     Maryland		
	Usual Residence of Decedent		91						Aug.	25 1909	iviar	ii y latiu	
Ì	10a. State 10b. County	ty, Town or Location								10d. Inside (	Dity Limits		
ł	MD Baltim	ockeysville								1 ☐ Yes	2 No		
5	10e. Street and Number			10f. Zip Code					10g. Citizen of What Country?				
	5 Gibbons Blvd.				21030				USA				
	11. Marital Stetus	12. Wes Decedent Ever in U,S Armed Forces? 1 Yes 2 No If Yes, Give		,S. 13.	S. 13. Was Decedent of If Yes, specify Cu			l Hispanic Origin? (Specify Yes o Joan, Mexican, Puerto Rican, etc			e · Ameri k, White.	can Indian, etc.	
ı	1 Never Merried 2 Married									Specify		White	
1	3 Widowed 4 □ Divorced		Year or Dates:					o Specify:			opecny. White		
	15. Decedent's E	16a. Dece	16a. Decedent's Usual Occupation (Give kind of work done during most of we life. DO NOT use retired)					16b. Kind of Bu	usiness/îr	ndustry			
ŀ	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or			+) life. DO NOT use retire				9d)					
fa annudura an	12 n/a			Homemaker						Own	Own Home		
	17. Father's Name (First, Middle, Last,	17. Father's Name (First, Middle, Last)			18. Molt				's Name (First, Middle, Meiden Sume			me)	
I	Addison E. Rob	inson			An				na Benk				
ŀ	19a. Informant's Neme/Reletionship (	Type Print)		19b. Mail	ing Addre	ss (Stree	t end Numb	er or Ru	ral Route Numb	er, City or Town,	Stete, Zi	io Code)	
ı			·/daugh		_								
ŀ	Marie E. Noppenberger/daughter 5 Gibbons Blvd., Cockeysville, MD 21												
20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, cremetory or other piece)  20c. Location - City or To Compare the													
1	4 Donation 5 Other (Specify)  Dulaney Valley Memorial Gardens Timonium, MD												
21. Signature of Employed Changes 22. Name and Address of Facility													
-	Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093												
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line.												Approxima	
1	shock, or heart failure. List only	one ceuse on	each line.									Onset and	tween Death
	Immediate Cause (Final												
	disease or condition a CONGESTIVE HEART FAILURE									<u> </u>			
	Due to (or as a consequence of):												
											i		
	Sequentially list conditions,	or as e conse	as e consequence of):										
	if sny, leading to immediate cause. Enter Underlying Cause (Disease or injury c.												
ı					s a consequence of):								
I	TOSURING IT WORKING EAST									1			
I	The second second	d						-			1		
ŀ	Part It Other elanificant conditions of	contribution to a	leath but not rea	ulting in the	underlying	COURD O	iven in Part		23h Did	tobacco use co	ntribute	to the cause	of death?
١	Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse									23b. Did tobacco use contribute to the cause of deat  1 Yes 2 No 3 Probably 4 Unkno			
I									'''	198 2 NO	3 L R	obsory 42	) Ollkilowi
I	24a. Wes an autopsy									an autoney	24b. V	Vere autopsy	/ findings
I									performed?		available prior to completion of ceuse		
									0	deeth?			
	1 ☐ Yes 2 ☑ No										-1	☐Yes 2[	□No
ŀ	25. Was case referred to medicei 26. Piace of Death (Check only one)												
	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatie	ent 3 🗆 (	OOA O	thor:			dence 6 🖾 Oth	er (Spec	ity) HOS	PICE
1	27. Menner of Death		of Injury oth, Day Year)	28b. Time			jury at ork?			how injury occur		,,	
	1 Natural 5 Pending investigatio		nth, Day Year)	Injury									
1	3 ☐ Suicide 6 ☐ Could not b		28a Place of Injury - Al home 4						28f. Location (Street and Number or Rural Ro		ral Route Nu	mber	
	4 Homicide determined	of Injury - Al home, farm, street, fectory, office ing, etc. (Specify)						City or Town, Stele)					
1													
1	29a. Certifier 1 Certifying Pt (Check only 2 Medical Exer												u(e)
	one) 2 Medical Exam		nner stated.	stron and/of I	iivesiiQati(	лт, н <del>т п</del> пу	opinion, de	alli occu	ned at the time,	date and plece,	-110 008	11.0 00000	(-)
1					1 .								

State Registrar RD.

DULANEY VALLEY

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

2300

32. Registray's Signature

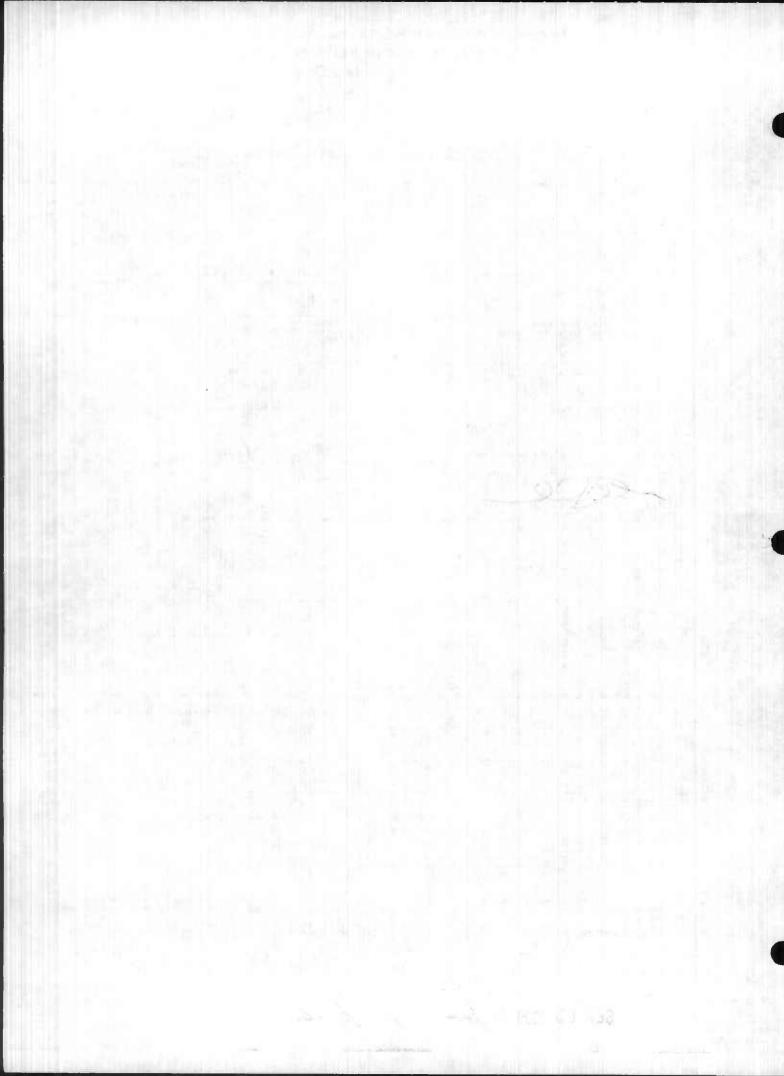
DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

SEP 1 5 20

3725

TIMONIUM, MD 21093



00-5208-510 Please Type or Print in Black indelible ink. Assure All Copies Are Legible. ARL REYNOLDS Amended Items #20b, 20c perFHG790 12/67200 of Maryland / Department of Health and Mental Hygiene JVW amend item 23a, 27, 28a, b, c, de, fper me G790 12/5/00 yf Certificate of Death 1. Decedent's Name (First, Middle, Last), 2. Date of Deeth 3. Time of Death Month Day **Physician** SEPTEMBER 14,2000 12:08 A.M. /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death **Examiner** SHOCK TRAUMA BALTIMORE If Under 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign Country) 6. Sex **Funeral** 12 M 2□ F Months Days Hours Min 8-80-093 Director Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Lecation 10d. Inside City Limits 28a-f show 1 Yes 2 □ No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe d 6 d Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race American Indian 11. Marital Status Black, White, atc. 1 ☐ Yes 2 No If Yes, Give Year or Datas: 1 Never Married 2 ☐ Married 1□ Yes 2 No Maryland 21215-0020 Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 0 17. Fathar's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiderl Sumeme) Be If Health end Mentel Item 27 is marked o 2 19a. Informant's Name/Ralationship (Type, Print) (mother 19b. Meiling Addrass (Street end Number or Paral Routa Number, City or Town, Stata, Zip Code) d.2 Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition-Department of I Important: If he any Injury or of pnce. 1 Buriel 2 ☐ Cremefion 3 ☐ Removel from Stele KING MEMORIAL PARK 4 ☐ Donation 5 ☐ Othar (Specify) 9/21/2000 Baltimore, Md 21. Signether of Funeral Servi 22. Name and Address of Facility tome Joseph RUS unera Ave. W, North 23a. Part I. Enter the wease, or complicities that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, around or have the literature. List only one ceuse on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) BLUNT FORCE INJURIES OF THE HEAD WITH COMPLICATIONS Examiner Due to (or as a consaquence of) Examiner The law requires that the deeth certificate be executed Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last Due to (or es e consequence of) pue Box 68760, ettending physicien Physician/Medicai Due to (or es e consequence of) P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown been signed by a should be detact 1 Yes 2 No 3 Probably Division of Vital Records, py 24b. Wara autopsy findings evailable prior to completion of cause of death? page 2 should 24a. Wes an autopsy Completed certificate hes Yes Yes 2 No 2 No Physician: Be 25. Was casa raferred to medicel 28. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28d. Dascribe how injury occurred subject struck 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Certification: 28c. Injury at Work? After t 5 Panding Investigation or Attending s effer deau... 1 Natural unknown September 8,00 1 Yes 2 XNo 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
Sidewalk 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1102 Common 111 lilled in by 4 XHomicida 1103 Carrollton Ave., Baltimore, Md within 24 hours To the Funerel To the Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) end mannar stated. edical 29e. Certifier completely 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture and fitting continu O.C.M.E. SEPTEMBER 14,2000

State Registrar

Mike THEUNUNE. 31. Date filed (Month, Day, Year) 1 5 2000

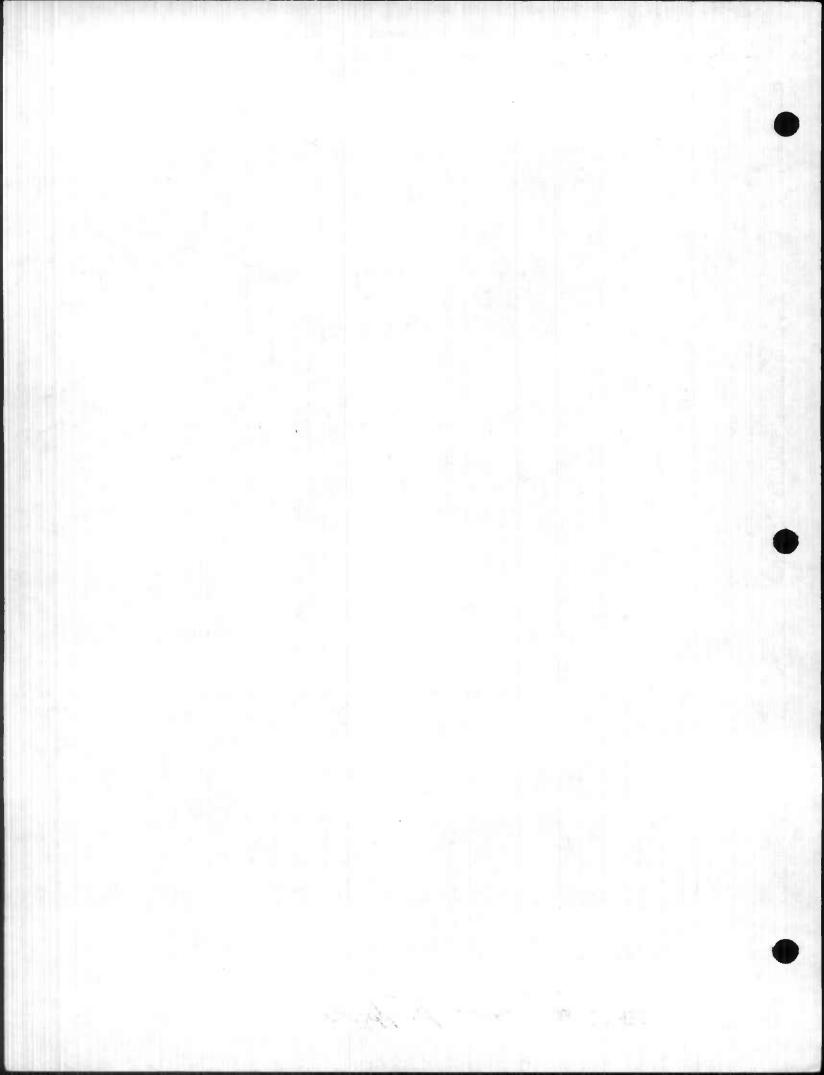
SEP

30. Nama and addrass of person who completed cause of das 100

32 Registrer's Signature

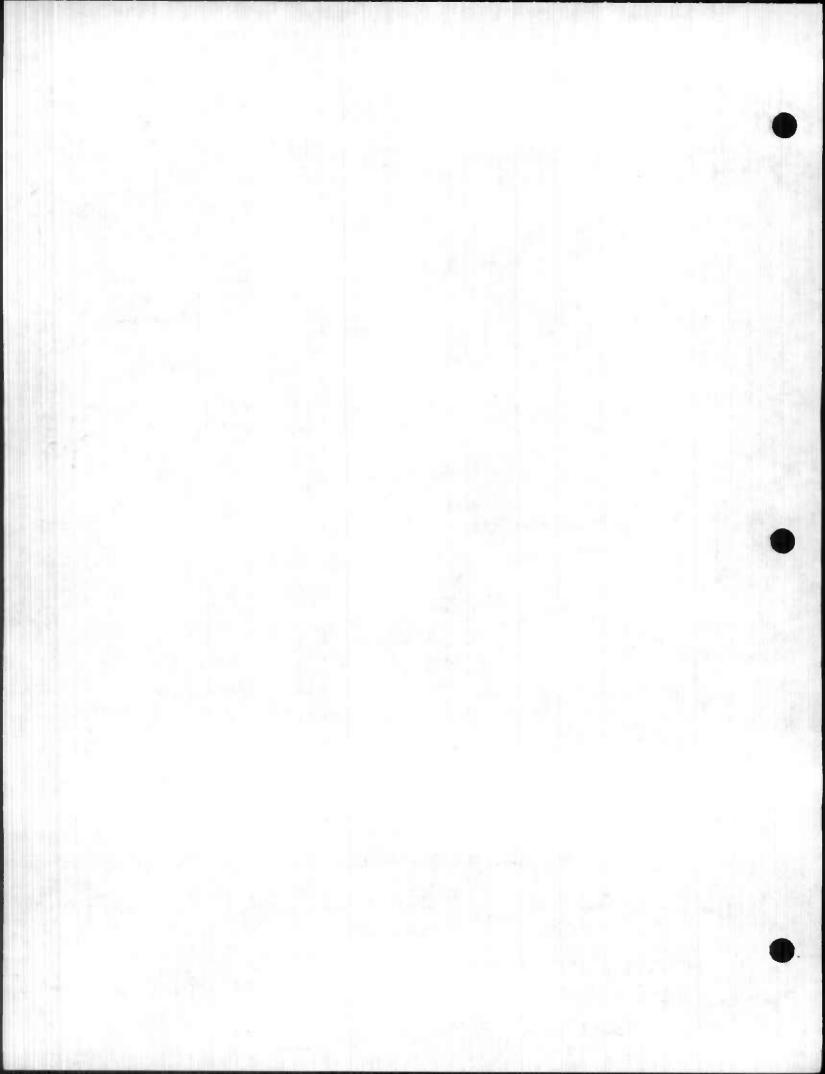
111 Penn Street, Baltimore, Maryland 21201

m 23a) (Type, Print)



			ryland / Depa	rtificate of		F	leg. No.	0 2	9236
Physician /Medical	1. Decedent's Nama (First, Middle, Las FREDER CK		REITTE		4b. City, Town, or l	2. Date of Dea Month SEPTEMBL	R 12 2	Year 2	:52 PM
Examiner  Funeral  Director	4a Facility Name (If not institution, give HAR PSDR HOSP 17AC 5. Social Security Number 6. St 213-26-4393	CENTER	(In yrs. lest birthday) 71 Yrs.		PACTIM OR If Undar 24 Hrs. Hours Min.		N/A		(State or Foreign
the Meryland 2844 show potted at	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo		J.				Inside City Limits 1 □ Yas 2X No
	MD Balti 10e. Street and Number 3012 Vermont Ave		Baltimor	e Highlar 10f. Zip Code 21227	ias		10g. Citizen of W		
020 urs after al., or the	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant Ev Armed Forcas? 1 Yas 2 No If Yes, Give Yaar or Datas:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes ※ No	tispanic Orlgin? (S. an, Mexicen, Puert Specify:	pecify Yas or No- o Ricen, efc.)	14. Race Black Specify:	e - American li k, White, etc. White	
d within giene.	15. Decedent's Ed (Specify only highast gra Elementery/Secondery (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wor d)	king	16b. Kind of Bu Servi		y
Maryland 2 d 2 should be filled th end Mental Hygi 7 is merked other traumatic event, I	17. Fathar's Nama (First, Middla, Last) Frederick W. Rei 19a. Informant's Name/Relationship (7)			ing Address (Street		arie Dor	n		da)
re, s 1 en Heal	Edna M. Reittere  20a. Method of Disposition  1	er, wife Removal from Stafe	30 20b. Place of Disp	12 Vermon osition (Neme of metory or other pla	nt Ave.	Baltimor Date 9-14-00		ands,	MD. 21227 State
Baltimo pemit. Pege: Department of Important: If is any injury or ance.	21. Signature of Funeral Service Licen	Inh		2. Name and Addre imbrose Fu 328 Sulpl				MD. 21	227
Physician /Medical Examiner	23a. Part1. Enter the disease, or compshock, or heart failure. List only a limmediate Cause (Final disease or condition resulting in death)	a. CARDIOC		HOCK quence of):	ng, such as cardiac	or respiratory ar	resf,	Inti	proximate erval Between set and Death  DAYS
ords, P.O. Box 68760, requires that the death certificate be executed een signed by the attending physician and hould be deteched for use as the buriel-transit eted by Physician/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	. ACUTE	ue to (or es a conse MYOCARDIA ue to (or as a conse	quence of):  AC (N)  quence of):				5	DAYS DAYS.
al Records, P.O. Box ( The law requires that the death certified has been signed by the attending, page 2 should be detached for use a Completed by Physician/M.	Part II. Other algnificant conditions of CHRONIC OBSTR	entributing to death but						atribute to the	e cause of death?
If Record The law require ate has been si page 2 should Completed	CHRONIC REN	AL FAILU	RE			24a. Was perfo	an autopsy med?	availat	autopsy findings ble prior fo afion of cause th?
On of Vita	25. Was case referred to medical examiner?  1  Yes 2 No  27. Memor of Death 1 Natural 5 Pending investigation	Hospital: 1 Inpatien 28a. Dete of Injury (Month, Dey		of 28c. Inju	ner: 4 Nursing H	eth (Check only of dome 5 Residuelle 1 28d. Describe I			
Division  or Attending s after death. In Director: After d in by the fune Certification	2 Accident investigation 3 Suicide 6 Could not be determined		y - At home, ferm, st (Specify)			28f. Location (S City or Tox	Street end Numb vn, Stete)	er or Rurel Ro	oute Number,
Division C To the Hospital or Attending P. within 24 hours after death completely lilled in by the funera Medical Certification:	(Check only 2 Medicat Examone)	relcian: To the best of iner: On the basis of e and manner stafe	xaminetion and/or in	nvestigetion, in my	opinion, deeth occu	erred at the time,	dete end place,	and due to the	e ceuse(s)
	29b. Signature and titla of certifiar  Why C  30. Name and address of person who certifian	completed cause of dea	Mb		2 136		29d. Date signed		
State Registrar  DHMH 16 Rev 6/95	GING TANG-OX 31. Date filed (Month, Dey, Year) SEP 15 2	/	300 /		NOVER S	st. B	ALTIMON	RE N	10 21 225

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 29237

	Certificate of Death	Reg.	No.	
15-2	1. Decedent's Name (First, Middle, Last)	2. Data of Death Month	Day Year	3. Time of Death
Physician /Medical	Gordon E. Rhodes	EPTEMBER		00 12:15PM
Examiner	4a Facility Name (If not institution, give street and number)  4b. City, Town, or Lo	ocation of Death	4c. County of Death	h
	GREATER BALTIMORE MEDICAL CENTER TOWSON	2.118	BALTIMO	DRE
Funeral	5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 1 Under 1 Year 1 Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birti	hplace (State or Foreign
Director	215-22-8604 73 Yrs.	December		I11.
2	Usual Residence of Decedenf  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
fany fany fan				1 ☐ Yes 2 ☑ No
or 28e-f.	Maryland Baltimore Co. Baltimore  10e. Street and Number 10f. Zip Code	100	Citizen of What Co	untov?
	2610 7 1 2 2 2	Tog.		
The doubt there 23 sine must	2618 Brad Well Court 21234  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spr	ecify Yas or No-	U.S.A	
20 arthur or the control of the cont	HVan Circ. TT TT 10 Van OF No. Creation	Rican, etc.)	Black, White	a, etc. White
DOOZ MANAGE	3 Widowed 4 Divorced Yaar or Dates:	Audio 1		
21215-0020 ad within 72 hours at Spiene. ser than "natural", or it, the Medical Exam	15. Decedent's Education (Specify only highest grada completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired)	ing 16b	. Kind of Business/	Industry
12 miles	Elementary/Secondary (0-12) College (1-4or 5+)  12 4 Manufacturers Represent			G
	12 4 Manufacturers Represent 17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Maid		Controls
land of the fire of the server		e Rhodes	Maria de la companya della companya	
Maryland as should be fine in and Mental Hy. The marked oth treumatic event	19a. Informant's Neme/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run			7in Code)
Mad 2 st of 17 st of	Mary L. (nee Barnes) Rhodes (Wife) 2618 Brad Well Court			
Te. 1 ar Hoss other other	20a. Method of Disposition 20b. Place of Disposition (Nama of	Date 20c	. Location - City or	Town, State
altimore, mir. Pages 1 a patiment of Hea portant: If Nem y Injury or othe	1 Burial 2 Aremation 3 Removal from State 4 Donation 5 Other (Specify)  Hilltop Service Corp. 9/	/15/2000	Towson	Maryland
altin	21. Signature of Funeral Service Licensee 22. Name end Address of Facility			-
CO SOLES		Towson Fu		
	23a Part Lengt the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac of about, or meant failure. List only one cause on each line.	York Rd.		Approximate
Physician	shock, or heart failure. List only one cause on each line.			Interval Between Onset and Death
/Medical	Immediate Couse (Final			
Examiner	disease or condition resulting in death)  Due to (or as a consequence of):			
executed in and instransit	Sequentially list conditions.  Due to (or as a consequence of):			
60, be exe ician a bunal-	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury			
I Records, P.O. Box 68760, The law requires that the death certificate be exate has been signed by the attending physician page 2 should be detached for use as the bural completed by Physician/Medical E-	that infliated events resulting in death) Last  Due to (or as a consequence of):			
C 65				
Il Records, P.O. Box  The law requires that the death certi- sate has been signed by the attending, page 2 should be detached for use a  Completed by PhysicianA	0. 0.000			
O. of deep the all the	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Dld tobec	cco une contribute	to the cause of death?
P.O. that the dead by the detached	Diabetes Mellitus Type 2	1 Yea	2 1 No 3 □ P	robably 4 Unknown
As, Fast that signed I be det	- District of the same		Ton	142
COrd requir	(380)	24a. Was an ai	12	Ware autopsy findings available prior to completion of cause
Rec e law has b				completion of cause of death?
The la		1 ☐ Yes	212 No	1 ☐ Yes 2 ☐ No
ysician: The ysician: The securificate director, pag	examiner	h (Check only one)		
hysic physic aldin		me 5 Residence		cify)
C P Jet C	1 ☑Netural 5 ☐ Pending (Month, Day Year) Injury Work?	28d. Describe how i	njury occurred	
Sic Seath tor: /	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be	201 Lanting (State	and Number or Ri	ural Bauta Mumbas
or At Mrec Sirec in by	28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, S		urar Proute Mumber,
la la la la la la la la la la la la la l	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and piece,		-(-)	a state d
DIVISION C Me Hospital or Attending P Me Funeral Director: Affect pletely filled in by the funeral	(Check only)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred and manner stated.	red at the time, date	and placa, and due	to the cause(s)
DIVISIO To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the It	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Mont	th, Day, Year)
F3F8	055916		9/14/2	DOD
1.	5			
0	20. Name and address of person who completed cause of death (flem 23a) (Type, Print)  RICHARD KWM, MD, 6701 N. CHARLUS ST., # 4903, B.	ALTIMORE	IG am,	204
State	31. Date filed (Month, Dav. Year) 32. Registrar's Signature			
Registrar	SEP 1 5 2000 Deneva & sparks			

	MEND#8 19B	PER F.H.	G787	9-15-200	O JAB	Ce	ertificate of	f Death		Reg. No.		
_	1. Decedent's Nan	ne (First, Middle	e, Last)						2. Date of Dea	ath Day	Year	3. Time of Death
an al	Joseph			Ramsev					Sept.		2000	11:59 P.
er	4a Facility Name	(If not institution	n, give str					4b. City, Town,	or Location of Death	4c. Count	ty of Deal	th
	Gilchris	t Hospi	ice C	enter			X	Towson	n	Balt	timo	ce
	5. Social Security	Number	6. Sex		ge (In yrs.	last birthda	y) If Under 1 Yea		Hrs. 8. Dale of Birt	h 9-14-16 y, Year)	9. Bir	hpiace (State or Fore
	082-16-5	026	1 05 2	# 2□ F	83	Yrs.	WOITIS Day	S Hours	09/04/1	916	Oh:	
	Usual Residence											
	10a, State	10b. County				ty, Town or						10d. Inside City Lim
Director	MD	Baltin	nore	11.00	1	Luther	Allie					1 ☐ Yes 2 💢
lre	10e. Street and No	ımbar	11/0		Total Till		10f. Zip Code		51125	10g. Citlzen of	What Co	ountry?
1000	612 Brig	htwood	Club	Drive			21	093		USA		
Funeral	11. Marifal Status		12	. Was Deceden	t Ever in U	,S. 13	. Wes Decedent of	Hispanic Origin	? (Specify Yes or No- uerto Rican, etc.)	- 14. Ra		nicen Indian,
3	1 Never Mar	ried 2 Marr	ried	Armed Forces		35-			derio riican, etc./		ack, Whit	9, 9tC.
by	3 Widowed	4 Divorced		If Yes, Give Year or Dates	195	54	1□ Yes 2 <b>K</b> N	o Specify:		Speci	ity:	White
ted		15. Decedent	t's Educa	tion		16a. Dec	edent's Usual Occ	upation		16b. Kind of E	Business	Industry
ple	Elementary/Sec	onders (0-12)	st grade d	College (1-4or	5.1	life	re kind of work don DO NOT use reti	red)	working			
Completed	12			2011090 (1740)	31,	Ope	rating M	anager		Oil 1	Indus	stry
Be C	17. Father's Name	(First, Middle,	Last)	1957				18. Mother's	Neme (First, Middle.	Maiden Suma	me)	
0 8	James Pa	lmer Ra	amsey					Griz	zglah Cor	bin		
	19a. Informant's N	lame/Reletions	hip (Type	, Print)	Mari				or Rural Route Number			
	Elizabe	th Rame	2037	Wife		612	BRIGHTWOOD	CLUB DR.	Luthervill	e. MD	2100	3
	20a. Method of Dis		J C y		20b. F	Place of Dis	position (Name of		Date	20c. Location	- City or	Town, Stata
		Cremation 5 □ Other (S)		noval from Slate	2		ematory or other p		09/18	Ho11144	aveb	urg, PA
-	21. Signature of F			1								
	21. Signature of F	1 1	Glonson	1					Schwab Fun			
- 32	Colu	J KY				1	36 Edmon	dson Ave	e. Baltim	ore, M	D 21:	228
	23e. Part1. Enter shock, or he	the disease, or art feilure. List	complica only one	tions that ceuse ceuse on each	ed the deat tine.	th. Do not e	nter the mode of d	lying, such as cer	rdiac or respiratory a	rrest,		Approximate triterval Between
												Onset and Death
	tmmediate Cause disease or conditi resulting in death)	(Final on		Car	dio	Rul	monery	Ar	rest			30 mi
	resuπing in death)			^	Due to (c	or as a cons	equence of):					
Examiner				Rest	sica	tory	Fail	we				6 Whs
Eam	Sequentially list o	onditions,			Due to (c	or as a cons	quence of):	Magazin			11.50	6 mon
E I	Sequentially list of any, leading to it ceuse. Enter Und Cause (Disease of	lerlying		Squ	gn	ous	Cell	Carc	o proch	flu	ng	6 mon
1 Ca	that initiated even resulting in death)	(S	U				equence of):			-		
N N												
any			d									
SICI	Part II. Other algn	ificant conditio	ons contri	buting to death	buf not res	ulting in the	underlying ceuse	given in Part t.	23b. Did	tobacco una c	ontribut	n to the cause of dea
P.	Sover	e ch	1001	vie or	site	mo An	ne Lun	ne Die	0018 10	Yaa 2□ No	3 🗆 P	robably 4 Unkn
þ	200					40		1 3				
8	Rulan	2.00.	5	1 006.2	fr.	~	Relie	· TL	24a. Was	an autopsy	24b.	Were eutopsy finding available prior to
ple	100000	7	, ,	21070	, , ,	374		1000	- 1			completion of cause of death?
			,						10	Yes 2 No		1 ☐ Yes 2 ☐ No
6	25. Was cese refe	rrea to medical	1			100		26. Plece of	Death (Check only o	one)		
		No	Ho	spital:	ient 2	ER/Outpat	ient 3 DOA	Other:	ng Home 5 ☐ Resi	/	ther (Spe	ocin) Ltospie
Be	examiner?			28a. Dete of In	jury	28b. Time	of 28c. In	ijury at	28d. Describe			
To Be	1 ☐ Yes 2 ☐ 27. Manper of Des			(Month, D	ay (edf)	Injury		Vork? □Yes 2□No				
To Be	1 Yes 2	ith 5 🗆 Pendin investig					street, factory, offic	28			nber or F	lural Route Number,
To Be	1 Yes 2 2 27. Manner of Des 1 Natural 2 Accident 3 Sulcide	5 Pendin	gation not ba						City or To	wii, Siaie)		
To Be	1 ☐ Yes 2 ☐ 27. Manper of Des 1 ☑ Natural 2 ☐ Accident	5 Pendin investig	gation not ba		otc. (Specif	197						
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edicai Certification: To Be	1 ☐ Yes 2 ☐ 27. Manper of Dea 1 ☑ Natural 2 ☐ Accident 3 ☐ Sulcide 4 ☐ Homicide  29e. Certifier (Check only one)	5 Pendin investig 6 Could reterm  1 Certifyin 2 Medical	gation not ba nined ng Phyalo Examine	building, e	t of my kno	wledge, de	investigation, in m	y opinion, death	occurred at the time,	date and place	e, and du	e fo tha cause(s)
Medical Certification: To Be	27. Manper of Dea  1 Matural  2 Accident  3 Sulcide  4 Homicide  29e. Certifier (Check only one)  29b. Signature an	5 Pendin investig	gation not ba nined ag Phyalo Examine	lan: To the best: On the basis and manner s	t of my kno of examina stated.	owledge, de- tion and/or	investigation, in my	y opinion, death	occurred at the time,	date and place	e, and du	e fo tha cause(s)
Medical Certification: To Be	1 ☐ Yes 2 ☐ 27. Manper of Dea 1 ☑ Natural 2 ☐ Accident 3 ☐ Sulcide 4 ☐ Homicide  29e. Certifier (Check only one)	5 Pendin investig	gation not ba nined ag Phyalo Examine	lan: To the best: On the basis and manner s	t of my kno of examina stated.	owledge, de- tion and/or	investigation, in my	y opinion, death	occurred at the time,	date and place	e, and du	e fo tha cause(s)

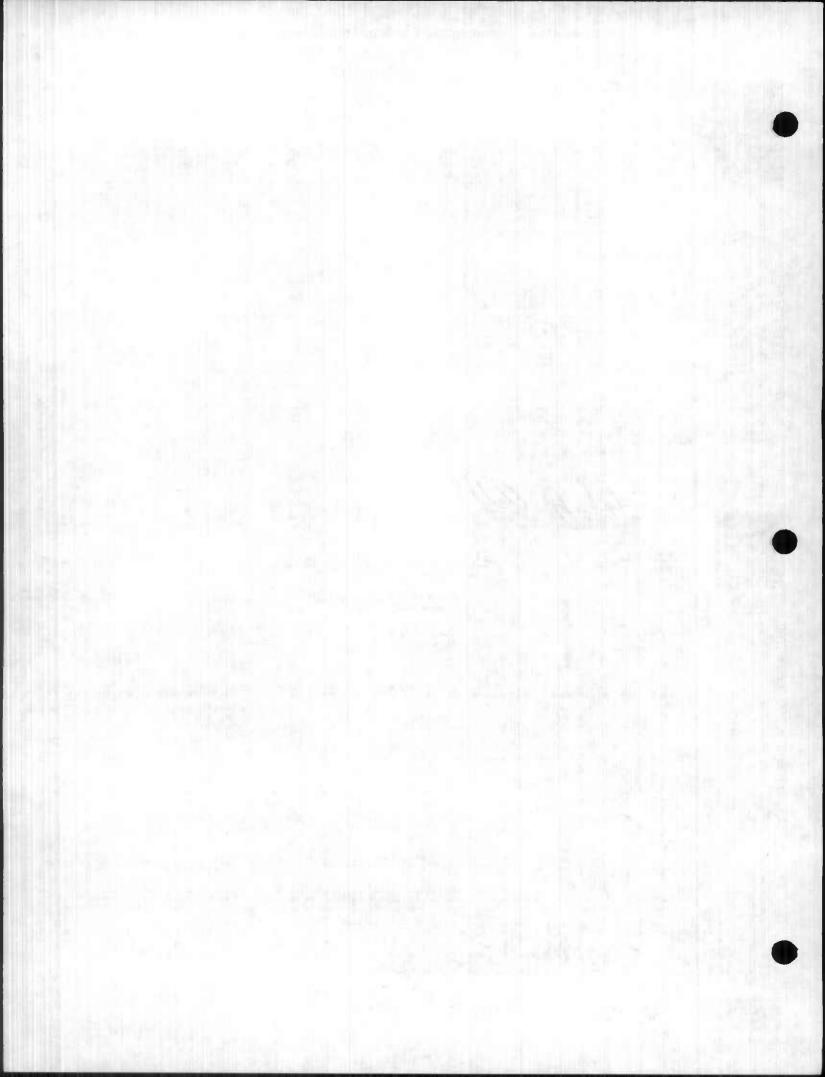
State Registrar DHMH 16 Ray 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

4.1 429

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29239

			C	ertificate	of Dea	th		Reg. No.			
	1. Decedent's Name (First, Middle, La	st)		100	DATE		2. Date of De Month	ath Day	Yaar	3. Tim	a of Death
Physician /Medical	William A. Reith	1					Septemb		2000	7:3	30 pm
Examiner	4a Facility Name (If not institution, giv	e street and number)			4b. City	, Town, or Lo	ocation of Deati	4c. County	of Death		
	Annapolis Nursing	& Rehabili	itation	Center	Ann	apolis		Anne	Arur	ndel	
Funeral Director	214 10 7040	ax 7. Age (	In yrs. last birthda 78 Yrs		Yaar If Un Days Hou		8. Date of Bir Month, Da JAN 20	th Y, 1922	9. Birthp MARY	lace (Sta	ta or Foreig
show	Usual Residence of Decedent  10a. State 10b. County  MD ANNE ARU		0c. City, Town or ANNAPO						1		e City Limits
here 23s or 28s-f shr ner must be notified a 'uneral Director	10e. Street and Number	V		10f. Zip (	Code 1401	30		10g. Citizen of USA			
e 23a	873 BOATSWAIN WA					0-1-1-2 (0-			ce - Amaric	on Indian	
Examiner mu Examiner mu by Funer	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Agned Forces? 1 12 Yes 2 No If Yes, Give Yaar or Datas:	WWII	If Yes, speci	77		ecify Yes or No Rican, etc.)	Bla	ck, White,		
ical rted	15. Decedent's Ed (Specify only highest gra		16a. De	cedent's Usual	Occupation	most of work	ina	16b. Kind of B	lusiness/Inc	dustry	
Med Apple	Elementary/Secondery (0-12)	College (1-4or 5+)		ve kind of work DO NOT use			n ny				
A, the Me	12	5+	LANI	DSCAPE	ARCHI'	TECHT		UNIVERS	TTY C	)F. ML	1
aren Be	17. Fathar's Nama (First, Middle, Last,				1			Maiden Sumar			
To To	ALEXANDER LESLIE	REITH			15	ABELLA		ONALDSC	114		
27 is my or traum	19a. Intormant's Name/Relationship (MARY CATHERINE RE		19b. Ma 87.	ailing Address BOATS	(Street and Nu WAIN W	AY ANN	APOLIS	er, City or Town MD 2140	, State, Zip 1	Code)	
unt: If hem uny or othe	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specific	Removal from Stata		sposition (Nem rematory or off CREMATO	har place)	9	Date -15-00	20c. Location BALTIM			•
any inju	21. Signature of Funeral Service Licer	2 All	1		sty Fu	neral	Home, I	P.A.	ID 214	101	
es the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last	C	Diration of the to (or as a constitution of the to (or as a co	sequenca of):			ccide	+	7	ten.	year year
d by the attending etached for use a Physician/M	Control of the state of the sta	d				N-41	DOL DIA	tobacco uss co			an ad death
signed by the d be deteched by Physic d by Physic	Part II. Other significant conditions of	ontributing to death but i	tot resulting in the	e underlying ca	use given in P	en i.		Yss 2□ No	3 □ Prol		Unknow
shoul ete							24a. Was	an autopsy ormed?	8V 00	ailable pr	osy findings for to of cause
page 2							10	Yes 200	10	Yas	No No
rector. pag	25. Was case referred to medical				26. F	Place of Deet	h (Check only	one)			^_
	examiner?	Hospital: 1   Inpatient	2 ☐ ER/Outpa	tient 3 DO	Other: I	1		dence 8 DOt	her (Specif	(v)	-11
After thi funeral	27. Menner of Death  1. Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Y	28b. Time	of 28	Sc. Injury st Work? 1 □ Yes			how injury occu		,	
Completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury building, etc. (	- At home, farm, Specify)	street, factory,	office			Street end Num wn, Stete)	ber or Rurs	al Route I	Vumber,
To the Funeral completely filled Medical C		ysician: To the best of r niner: On the basis of ex and manner state	amination and/or								se(s)
within 24 hours after To the Funeral Dir completely filled in Medical Cert	29b. Signalure and title of certifier	1 1 ~		29c.	Licansa numi	ber		29d. Date sign	ed (Month,	Day, Yea	ir)
10	> mad h	allo		1	)518	519		9/14	1/00	)	
W.	Matthew J.	completed cause of deal	1833	A. F	orest	- Dri	ue An	napolis	DM	) 2	1441
State	SFP 1.5 2000	32. Registrar's	Signatura	Spark	2						

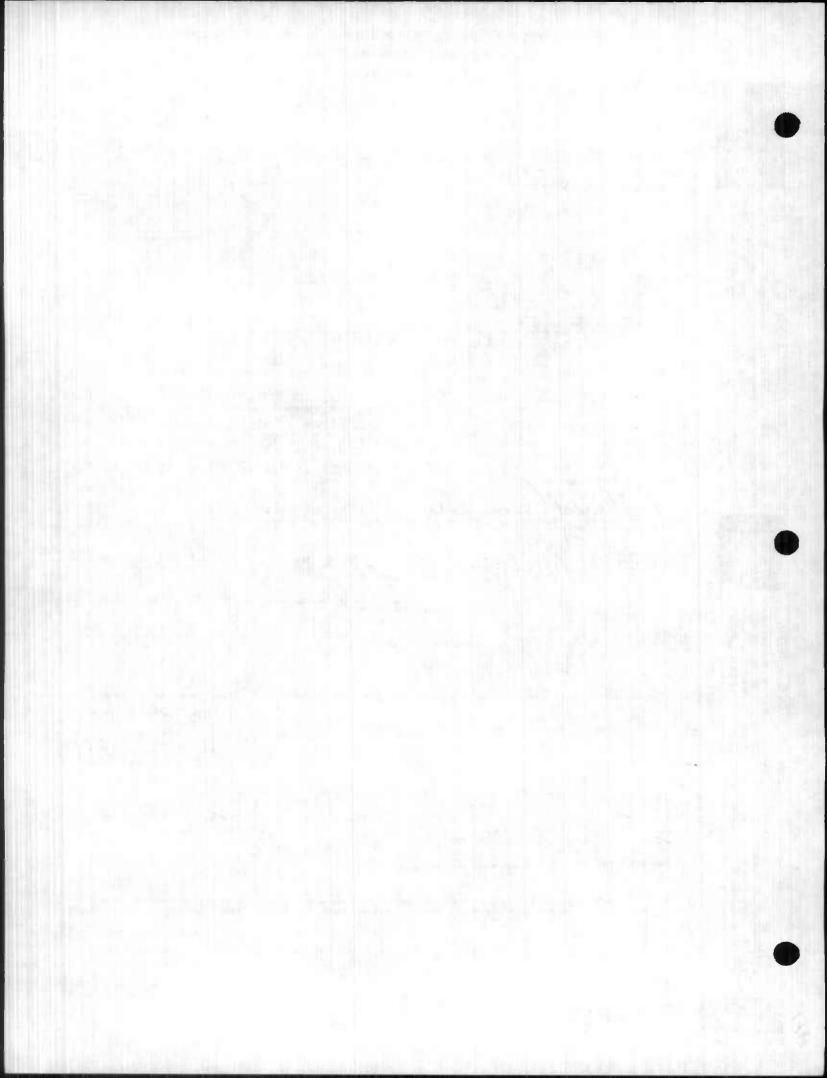


State of Maryland / Department of Health and Mental Hygiene Certificate of Death

29240

The second		ne (First, Middle, Las						2. Date of Dea	th Day	Year	3. Time of Death
Physician /Medical			EILE	EN PA	ATRIC	IA S	MITH	SEPT.	12 20	222	4:45pm
Examiner	4a Facility Name	(ff not institution, give	transfer ment	)			4b. City, Town, or	Location of Death	4c. County	of Death	
	123	Lariat				(Under 1 Vee	Middle			1time	
Funeral Director	5. Social Security 218–36–1	1335	9x □M 2K□F 7. A	ge (In yrs. last		Undar 1 Yaa lonths Days			,1939	9. Birthple Counti Mary	ice (State or Foreign Land
F 1	Usual Residence	10b. County		10c. City, To	own or Locati	ion				10	d. Inside City Limits
off the Maryland or 28s-f show be notified at	MD	Baltim	ore			Mid	dle River				1 ☐ Yas 2X No
1 5 M		<sub>umber</sub> Lariat Ro	ad			10f. Zip Code	21220		10g. Citizen of N USA		ry?
020 ars after duath virt. or thems 23 common must.		ried 2 Married 4 Divorced	12. Was Decedent Armed Forces 1  Yas 20 If Yas, Give Yaar or Datas:	? INo		S Decedant of as, specify Cu	Hispanic Origin? (S ban, Maxican, Puar Specify:	Specify Yea or No- to Rican, etc.)	14. Rad Blac Specify	e - America ck, White, e y: Whi	tc.
5-002 72 hours hartural', Scal Exa		15. Decedent's Ed	ucation	10	Sa. Decedent	's Usual Occ	pation	adulus a	16b. Kind of B	usiness/Indi	ustry
willing willing and the Man	Elementary/Sec 12th	ondary (0-12)	Collega (1-4or	5+)	life. DO		a during most of wo	rking	Helix	. Me	dstar
ind in the fine of other event,	17. Father's Name	(First, Middle, Last)					18. Mother's Na	me (First, Middle,	Maiden Suman		
aryland a should be flied at Mental Hyg marked other smalls event, I		Elliott	Barbour					a May A			
C C C C L		Smith / h	**	1		Address (Stree ariat	et and Number or R Road Ba	ural Route Numbe			Code)
Ore 1 or other		□Cremation 3 □		ceme		ory or other pi		Date	20c. Location		
Baltim semit. Pa Separtmen mportant my Injury nose		5 ☐ Other (Specify uneral Service Licen:		HO1.			ress of Facility	6/2000	Balti		Md.
m 32738	1 × K.	Tirry	(orm	Ille		300	elly Fune Mace ave.	Baltimo	re Mary		21221
Physician /Medical Examiner	Immediate Cause disease or condit resulting in death	on		1	ric (	Zolon	Cancer				Approximate Interval Between Onset and Death
P.O. Box 68760, nat the death certificate be executed by the attending physician and setached for use as the burist-transit Physician/Medical Examiner	Sequentially list of any, leading to it cause. Enter Unc Cause (Disease of that initiated even resulting in death)	IS The state of th	b	Dua to (or as							
h certification of the certifi			d								
D. Ba death	Part II. Other algn	iffcant conditiona co	entributing to death I	but not resulting	g in tha unde	rlying causa g	given in Part I.	23b. Dld t	obacco usa co	ntributa to	the cause of death
								1 🗆 '	rea 2000	3 Prob	ably 4 Unknow
COrc requi								24a. Was perio	an autopsy med?	con	ra autopsy findings ilable prior to apletion of causa eath?
The law te has sage 2								101	es 2 No	1 🗆	Yas 2□ No
Vital Ficien: The certificate rector, pag	25. Was case refa	rred to medicat					26. Place of De	ath (Check only o	ne)		
On of V aling Physici h. After this ce funeral direction: To E	1 Yes 20	TNO	Hospitat: 1 Inpati 28a. Date of Inj (Month, Di		Outpatient b. Time of Injury	3□ DOA C		Home 5 Aesid			)
Division of Vital Records, To the Hoopital or Attending Physician: The law requires the within 24 hours after deeth. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be a Medical Certification: To Be Completed by	2 Accident 3 Suicide 4 Homicide	investigation 6 Could not be detarmined					Yes 2 No	28f. Location (S City or Tow	Street and Numi m, State)	ber or Rural	Routa Number,
Hospit     24 hour     Funeral     ietely fille	29a. Certifie (Check only one)	1 Certifying Phy 2 Medical Exam	rsician: To the best iner: On the basis of and manner s	of axamination							
To the Comp	29b. Signature an	d titla of certifier	m.	D.			45390		29d. Date signe	d (Month, E	Day, Year)
5	30. Name and add	ress of person who o	completed cause of			2 # 21	06 , BAI	TIMOR	E, M	D 21	237
State	31. Date filed (Mo			trar's Signature	6	1					•

DHMH 16 Rav 6/95



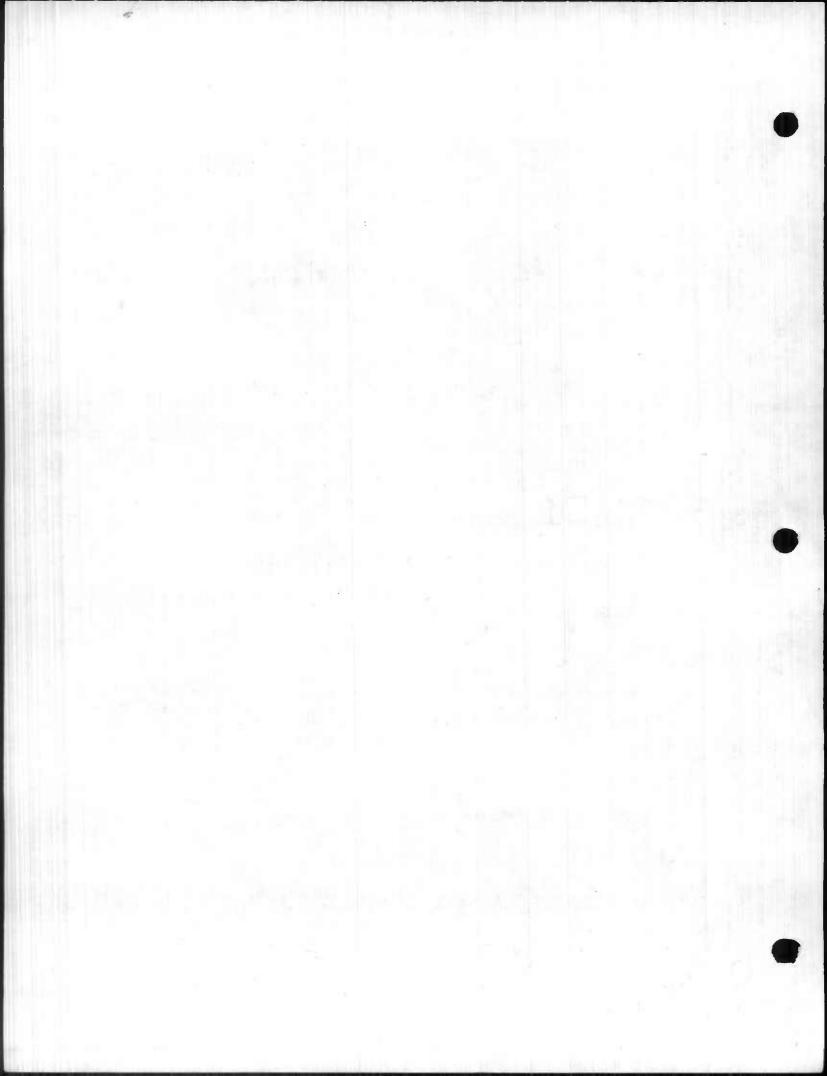
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Red No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 13, 2000 **Physician** Philomena M. Slifker 10:30 PM /Medical 4c. County of Death 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 841 N. Linwood Avenue Baltimore Hunder 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days Months 10 M 20 F 89 Yrs Director 213-30-5421 May 21, Unknown Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show must be notified 1€Yes 2 No Directo 2884 Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 floring 23a 841 N. Linwood Avenue 21205 S. A. и. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 natural, or 1 Yes 2X No Specify: à 3 Ø Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working title. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Produce 8th Grade 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental I int: If Nem 27 is marked or John Russo Josephine Russo 19e. Interment's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: if Iham 27 is any injury or other trau Mrs. Victoria M. Schmidt (Dghtr) 1530 Endsley Place, Cropton, Maryland 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer 19/16/00 Baltimore. Maryland 22. Name and Address of Facility
Schumuner Funeral Home Inc. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart tailure. From the one cause on each line. May 1 Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Mocardia Examiner Due to (or as a consequence of): Examiner VOV AT that the death certificate be assecuted attending physician and for use as the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a conse Box 68760. Physician/Medical the Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t 1 Y88 2 No 3 Probably 4 Unknown Records, Completed by 24b. Wera autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 Yes 20 No 1 Tes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical examinar?
1 Yes 21 No Be 26. Place of Deeth (Check only one) 211 No Other: 4 Nursing Home 5 DAesidence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manney of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After A hours after dea. 1 Neturel 5 Pending investigation 1 | Yes 2 | No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mannar as stated.

| Medical\_Examinent On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the On the besis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c, License number cause of death (Item 23a) (Type, Print)

Registrar

State

32 Registrar's Signature



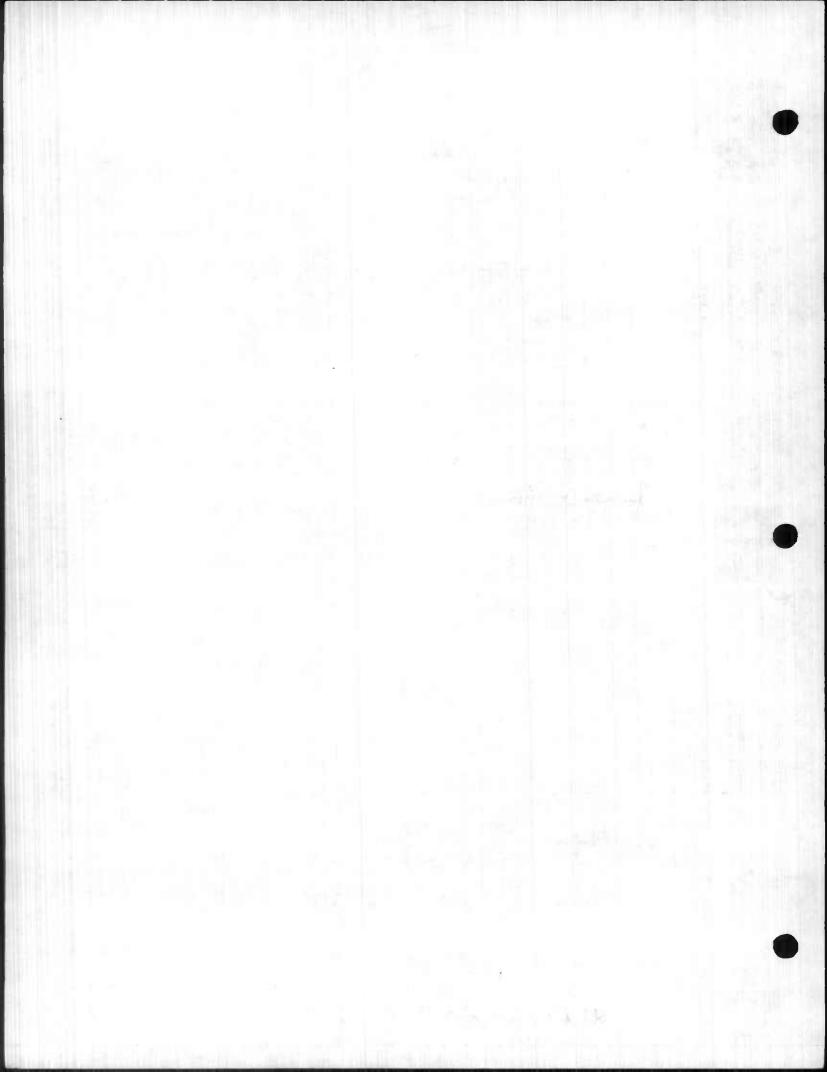
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Date of Death Month Year **Physician** Sept 2000 Eugene V. Saunders, Sr. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlestown Center f Under 24 Hrs. 8. Date of Bi Care Baltimore If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1⊠M 2□ F Director 220-24-8301 87 Missouri Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County r than "natural", or items 23s or 28s-f show the Medical Exemples must be notified at 10d. Inside City Limits Baltimore Catonsville 1 ☐ Yes 2 ☑ No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane CR504 21228 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 White 1 ☐ Yes 2 ☑ No Specify: Specify: 2 3 ☑ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Attorney permit. Pages 1 and 2 should be flist Department of Health and Mental Hy Important: if Item 27 Is marked ofth any Injury or other treumstic event pages. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Paul F. Saunders Johanna A. Sehrraushig 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 19a. Informent's Neme/Relationship (Type, Print) 22 Prairie Landing Court, N. Potomac, Maryland Dr. Eugene V. Saunders, Jr./son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Suriat 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Gate of Heaven Cemetery 9/15/2000 Silver Spring, MD 22. Name and Address of Facility
Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee uanita Thomas K 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, of heart feilure. List only one cause on each line. **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical YEar Drougyy Artery Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): physician s the burlal Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): 987 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 20 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? certificate has b 1 Yes 2 No 1 ☐ Yes 2 ☐ No Vitai Attending Physicien: 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of this 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Atta completely filled in by the fun. 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number VMary 51051 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mdidenthoice lane, catonivillo, Mp, 2/228 Andres Salgrar 32. Registrar's Signature SEP 1 5 2000 > Senew Registrar **DHMH 16 Ray 6/95** 

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Saunders

Lugene

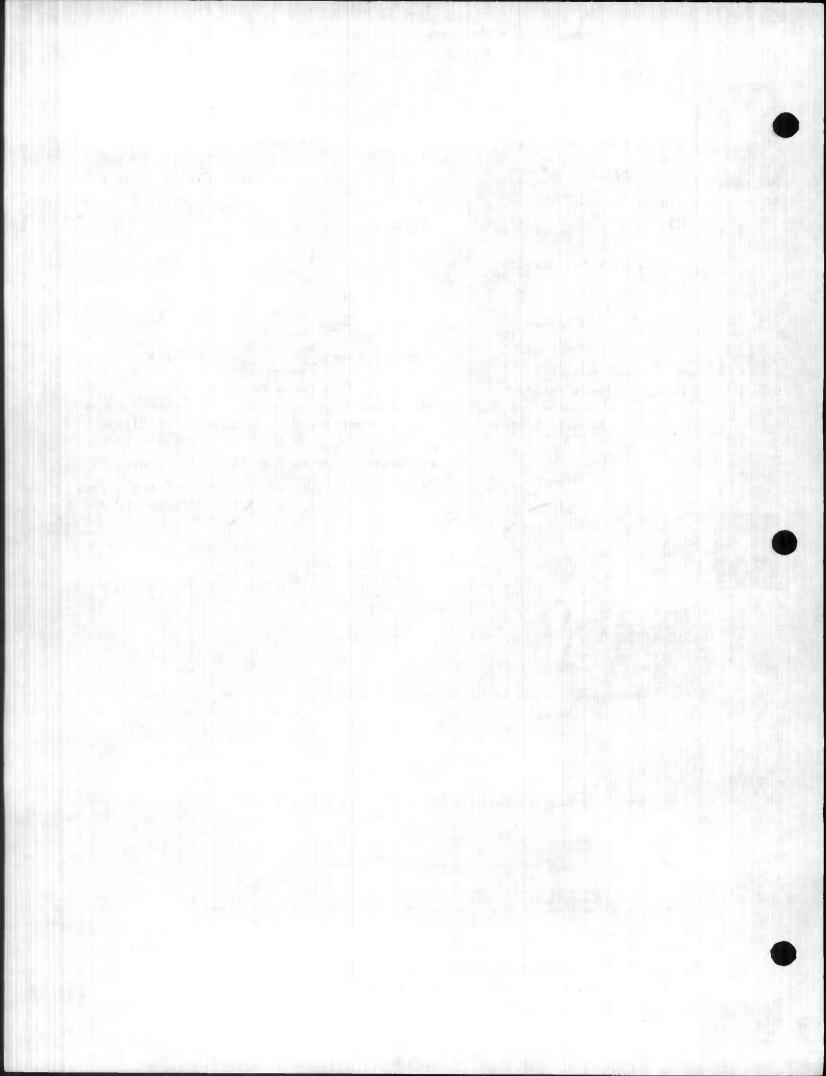
Name



State of Maryland / Department of Health and Mental Hygiene 10 2001.

				Certifica	ate c	of Death		Reg. No.		47640
Physician	1. Decedent's Name (First, Middle, La					DE TEAL	2. Date of Do		Xear	3. Tima of Death
Medical	Robert F.	Schar	f				Sept.		000	8:10 A
xaminer	4a Facility Name (If not institution, given	The state of the s				4b. City, Town, or	Location of Deal	th 4c. Count	y of Death	
	814 S. Conkling					Baltimo				
ral	5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birth	Month	der 1 Ye			rth ey, Year)	9. Birthpli Count	aca (Stete or Foreign (ry)
or	212-30-6068 Usual Residence of Decedent		67 '	rs.			08/28/	1933	New J	lersey
	10a. State 10b. County		10c. City, Town	or Location					10	od. Inside City Limits
6	MD								-	1 XYas 2 No
Directo	10e. Street and Number		bal	timore	Zip Cod	•		10g. Citizen of	What Count	Inv?
	Too. Ottool and Nombol			101.			100		TTTTAL COUNT	.,,
Funeral	814 S. Conkling	Street 12. Wes Decedent Ev	er in IIS	13 Was Da		1224	Specify Ves or N	USA 14 Ra	ca - America	an Indian
ä	1 Never Married 2 Married	Armed Forces?		ft Yes, s	pecify C	of Hispanic Origin? (Suban, Mexican, Puer	to Rican, etc.)	Ble	ack, White, e	
by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 1	No Specify:		Speci	y: Whi	to
	15. Decedent's E	<u></u>	16a. I	Decedent's U	sual Oc	cupation		16b. Kind of I		
Completed	(Specify only highest gro	ede completed)		Give kind of life. DO NO	work do	ne during most of wo	nrking			
E O	Elementary/Secondary (0-12)	College (1-4or 5+		uck Dr	ive	r		Truck	ing	
BeC	17. Father's Name (First, Middle, Last	)					me (First, Middle			
9	George Wilbert S	charf				Agnes I	Bosch			
-	19a. Intermant's Neme/Relationship		19b.	Mailing Addr	ess (Str	eet and Number or R		ber, City or Town	n, State, Zip	Code)
	Ella Marie Manger	Sister				ling St.				
	20a. Method of Disposition		20b. Place of cemetery				Date	20c. Location		wn, State
	1 Burial 2 Cremation 3 C 4 Donation 5 Other (Special					Jesus Cer	00/1/	Baltim	ore M	m
4	21. Signature of Funeral Service Lie									
Old I	7714 1/				-	dress of Facility Shton Matt				
	14hur Je Ke					ow Springs				
- 6	23a. Part1. Enter the disease, or com shock, or heart tallure. List only	one cause on each line	ne death. Do ni	ot enter the m	1008 01	gying, such as cardia	c or respiratory	arrest,	1	Approximate Intervel Between Onset and Death
an al	Immediate Course /Final	Myocardia	1 Infam	trion						Onset and Death
er e	Immediate Causa (Final disease or condition resulting in death)	a	т ппагс	LIUI						same
100	Tooling in outry	D	ue to (or as a co	onsequenca	ot):					
Examiner		b								
xar	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	D	ue to (or as e co	onsequenca	ot):					
	cause. Enter Underlying Cause (Disease or Injury	c								
edicai	that initiated events resulting in death) Last	D	ue to (or as a co	nsequence o	ot):					
- 5		d								
Physician										
ysic	Part II. Other significant conditions of	contributing to death but	not resulting in	the underlyin	g cause	given in Part I.	23b. Dtd	tobacco uss c		the causs of death
by Ph							11	Yes 2 No	3 Prob	ably 4 Unknow
by			100			LA CLEY	-		0.45 11/0	in distance tindings
Completed							24a. We	s an autopsy formed?	ava	are autopsy tindings allable prior to appletion of cause
npleted			1,2500	Televi					of c	death?
Com							1□	Yes 2 No	1□	Yes 201 No
Be	25. Wes case reterred to medical examiner?					26. Place of De	ath (Check only	one)		
To Be	1 Yes 2 X No	Hospital:	2 ER/Out	patient 3	DOA	Other: 4 Nursing	Home 50 Res	sidenca 6 🗆 O	ther (Specify	()
	27. Manner of Death 1 ♣ Neturel 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Ti	me of jury	28c. I	njury at Work?	28d. Describe	how injury occi	bernu	
atic	2 Accident Investigation	n		М		I ☐ Yes 2 ☐ No			100	
Medical Certifica	3 Suicide 6 Could not be determined		y - At home, tan (Specify)	m, street, tac	tory, off	Ce Ce	28t. Location City or To	(Street end Nun own, Stete)	nber or Rura	l Route Number,
Certification:			,-,,,							
edical		nysician: To the best of miner: On the basis of e								
	one)	and manner stete		or investigat	ion, in ii	ry opinion, deeth occ	urred at the time	, data end piace	t, and due to	(ile cause(s)
2	29b. Signeture and title of certifier	00				ense number		29d. Date sign		
	Daves	Sure	~ DO		H43	234		September	12, 20	000
	30. Name and address of person who	completed cause of dea	th (Item 23a) (T	Type, Print)						
	David Silver D.O.				, Md	21224				
State	31. Date filed (Month, Bay, Year)	32. Register	s Signatur	Long	Ks					
State	SEP 15 7000	Clemen	1	payson	400					

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death SEPTEMBER 12, 2000 **Physician** 2:05 PM **ESTHER** MACHT SCHINDLER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner BALTIMORE BRIGHTWOOD NURSING HOME LUTHERVILLE If Undar 1 Year | If Undar 24 Hrs. 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 KF 220-42-8705 93 Director AUG.12,1907 Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov the Mary 1 XYes 2 □ No Funeral Director MD N/A BALTIMORE the Medical Examiner must be notifi 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda Rema 23s or 4000 N. CHARLES STREET #406 21218 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedant Ever in U,S Armed Forces? 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 X No 1 Nevar Married 2 Married b 21215-0020 1 ☐ Yes 2 No Specify Specify WHITE by 3 Widowad 4 Divorced "netural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME Maryland 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Father's Name (First, Middla, Last) ahould be PHILIP MACHT SARAH LONG 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, State, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 at Department of Health and Important. If New 27 is n any injury or other traus otics. 11 E. FAYETTE STREET - BALTIMORE, MD 21202 AMY MACHT / GREAT NIECE Baitimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlal 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ARLINGTON CHIZUK AMUNO 9/14/00 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Entar the disaase, or complications that caused the death. Do not antar the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediata Causa (Final disease or condition resulting in death) /Medical PSIS one month Examiner Physician/Medical Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last use as the burial-tran pug Due to (or as a consequence of) Box 68760 the attending physician Due to (or as a consequence of): 23b. Dtd tobacco use contribute to the cause of death? P.O. Part It. Other eignificant conditions contributing to death but not resulting in the underlying causa givan in Part I. 1 Yea 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performad? page 2 should Be Completed certificate has 2 3 No 1 ☐ Yes 2 ☐ No 1 Yes al or Attending Physician: The street death.

In Director: After this certificated in by the funeral director, pa 25. Was case referred to medical 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Hatural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 6 Could not be dataminad 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) illed in by 4 Homicida To the Hospital e within 24 hours a To the Funeral D 1 Certifying Phyalcian: To the best of my knowledga, daath occurred at tha tima, date and place, and dua to the cause(s) and mannar es steted.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) 29b. Signature and title of corp

**DHMH 16 Rev 6/95** 

Registrar

31. Date filed (Month, Day, Year) SEP 15 2000

30. Nama and address of person

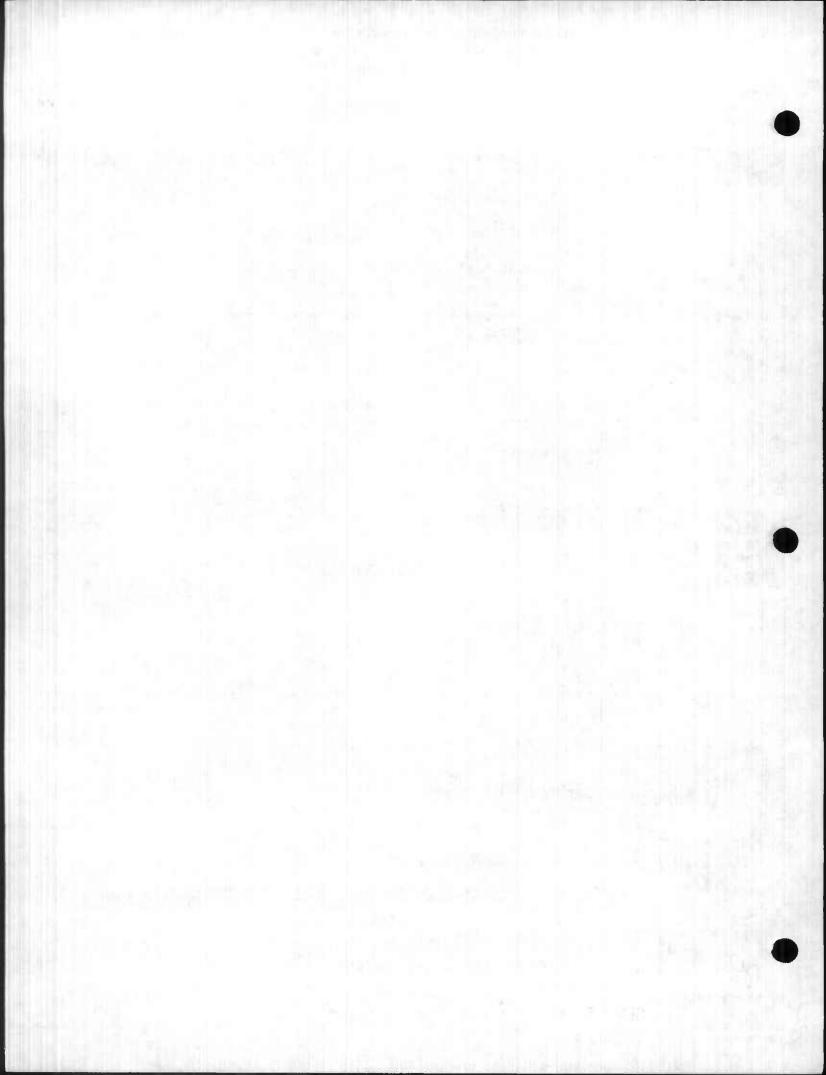
32. Registrar's Signatura

mpleted cause of

en

death (Item, 23a) (Type, Print)

1838 Graene True Rd \$300



State of Maryland / Department of Health and Mental Hygiene

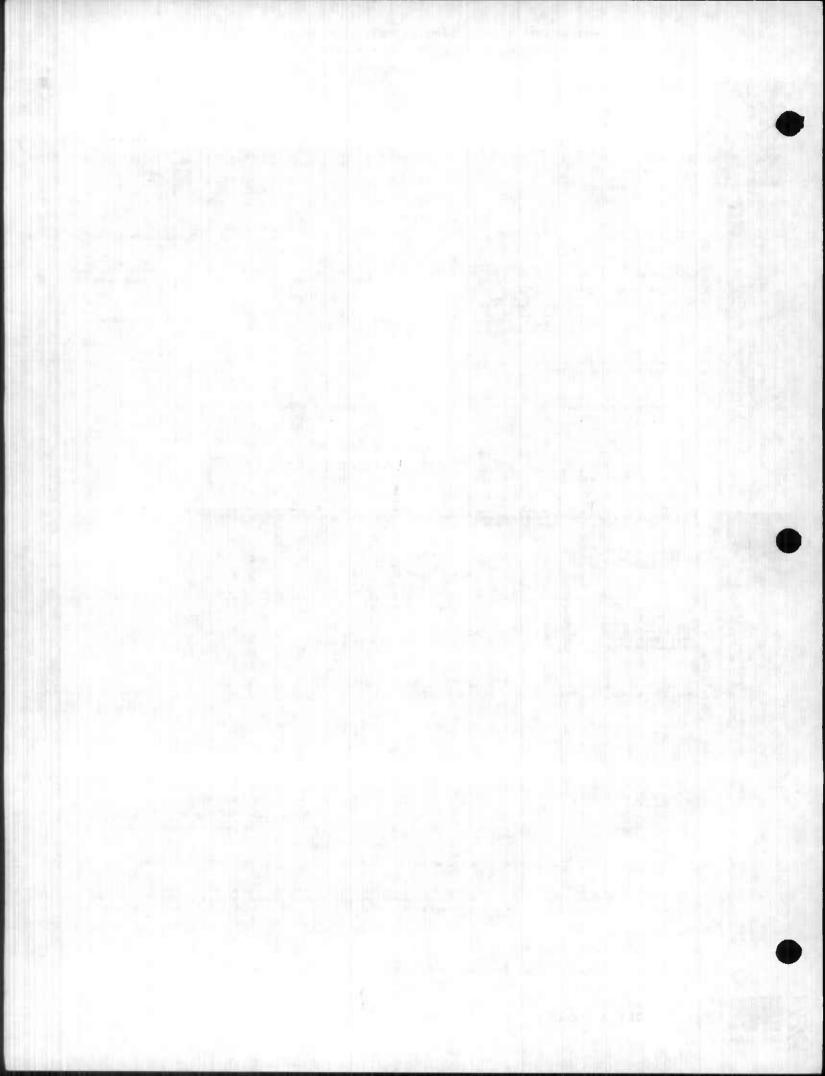
				ertificate of			leg. No.	29245
Physician	1. Decedent's Name (First, Middle, L			0		2. Date of Dea Month	Day	Year 3. Time of Death
/Medical	MARVIN		OLE	K	45 Ob Town	SEPTEMBE		2000 11: 45 AM
Examiner	4a Facility Name (If not institution, gradual SAMARITA		OF	BALTIMORE	4b. City, Town, or		4c. County	LTIMORE CIT
Funeral	Social Security Number 6.	Sex 7. Age (In yr.		(y) If Under 1 Year	If Under 24 Hrs			Birthplace (State or Foreign Country)
Director	220-14-4580	1⊠M 2□F	74 Yrs.	Months Days	Plours Min.	AUG.4,1	926	MD
D R.	Usuel Residence of Decedent  10a. Stata  10b. County	10c. 0	City, Town or	Location				10d. fnside City Limits
fled a	MD N	/A	BALT	IMORE				1 X Yes 2 □ No
or 28e-fa be notified Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Country?
	3800 FALLSTAFF	ROAD			21215			U.S.A.
ir, or hame 23st cominer must by Funeral	11. Merital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Wes Decedent Ever In Armed Forces?  1 ⊠ Yes 2 □ No If Yes, Give WW Year or Dates:	VII	3. Was Decedent of lift Yes, specify Cub 1 ☐ Yes 2 ☑ No		pecify Yes or No- o Rican, etc.)	14. Race Blee Specify	e - American Indian, ck, White, etc.
		Education	16a. De	cedent's Usual Occu	pation		16b. Kind of Bu	usiness/Industry
over than 'natural, the Medical.	(Specify only highest g	rade completed)  College (1-4or 5+)	(Gi	cedent's Usual Occu ve kind of work done n. DO NOT use retire	during most of wo	rking		
Con	12		DRI	VER			TAXI	47.40
Be son	17. Fathers Name (First, Middle, Las	<i>t</i> )	CMOT		F 19-3 Sales	ne (First, Middle,	Meiden Sumem	
To To	JERRY	(Time Drint)	STOL	ER ailing Address (Stree	KATIE	uni Dauta Mumba	City of Town	LEAN
The Part	19a. fnformant's Name/Relationship SHIRLEY P. STOLI			D FALLSTAE				
Man 2	20a. Method of Disposition		Place of Dis	sposition (Neme of		Date		City or Town, State
A set of	1 Suriel 2 Cremation 3			remetory or other ple		9/14/00	ВАГ.ТТ	MORE, MD
martin inju	21. Signature of Funeral Service Lice	AL	NSHE E	MUNAH)AIT2 22. Name and Addre				
ASESS	Best	7		2000 DETCT	PED CHYMAIN			BROS., INC. LE, MD 21208
	23a. Pert1. Enter the diseese, or con shock, or heart failure. List onl	inplications that caused the de						Approximate friterval Between
hysician	anous, or main failure. List offi	one cause on each mie.						Onset and Death
Medical xaminer	Immediate Cause (Final disease or condition	. GASTRO I	INTES	STINAL	B	LEED		
	resulting in death)	Due to		sequence of):				
n and Sel-transit Examiner		b. PEPTIC		LCER	DIS	EASE .		
n and Mitransit Exami	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or es a cons	sequenca of):				
De pri	that initiated events	C. Due to	(or as a cons	equenca of):				
D = W	resulting in death) Last	500 10	(3) 69 6 6016					
for use a		d						
the attended for ysicla	Part II. Other eignificant conditions	contributing to death but not re	esulting in the	underlying cause gi	iven in Part I.	23b. Did t	obacco uee co	ntribute to the cause of death?
detached detached						101	/ee 2□ No	3 Probably 4 Unknown
should be						24a. Was a	an autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?
page 2						101	as 2 No	1 ☐ Yes 2 ☑ No
rector, pag rector, pag	25. Was case referred to medical				26. Plece of De	eth (Check only o		
90	examiner? 1 Yes 2 No	Hospital:	□ ER/Outpa	ient 3 DOA	ther	lome 5 ☐ Resid		er (Specify)
	27. Manner of Death 1 Netural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injur		ury et ork?	28d. Describe h	now injury occur	red
death. ctor: Af y the fu ficatic	2 Accident investigation	on		M 1	Yes 2□No	001		0.00
Direct in by	4 Homicide determine	28e. Placa of injury - At building, etc. (Spec		street, factory, office		28f. Location (S City or Tow		per or Rural Route Number,
within 24 hours after death.  To the Funeral Director: After to completely filled in by the funeral Medical Certification:	29a. Certifier Certifying P	hysician: To the best of my ki miner: On the basis of exami and manner stated.	nowledge, de nation end/or	ath occurred at the t investigation, in my	ime, date and place opinion, death occ	a, and due to the curred at the time, o	cause(s) and ma date and place,	anner es stated. end due to the cause(s)
Vithin County	29b. Signature and title of certifier			29c. Licen	nse number		29d. Date signe	d (Month, Day, Year)
> = 0	Manisha P.	sahl M.I		P 13	3452	5	EPTEMB	ER 12 2000.
5	30. Neme end eddress of parson who	completed cause of death (It	em 23a) (Typ			CH RAVE	EN BO	VLEVARD
9	MANISHA BAHL	GOOD SAMARITA	AN HO	SPITAL				21239

Registrar DHMH 16 Rev 6/95

State

32. Aegistrar's Signature

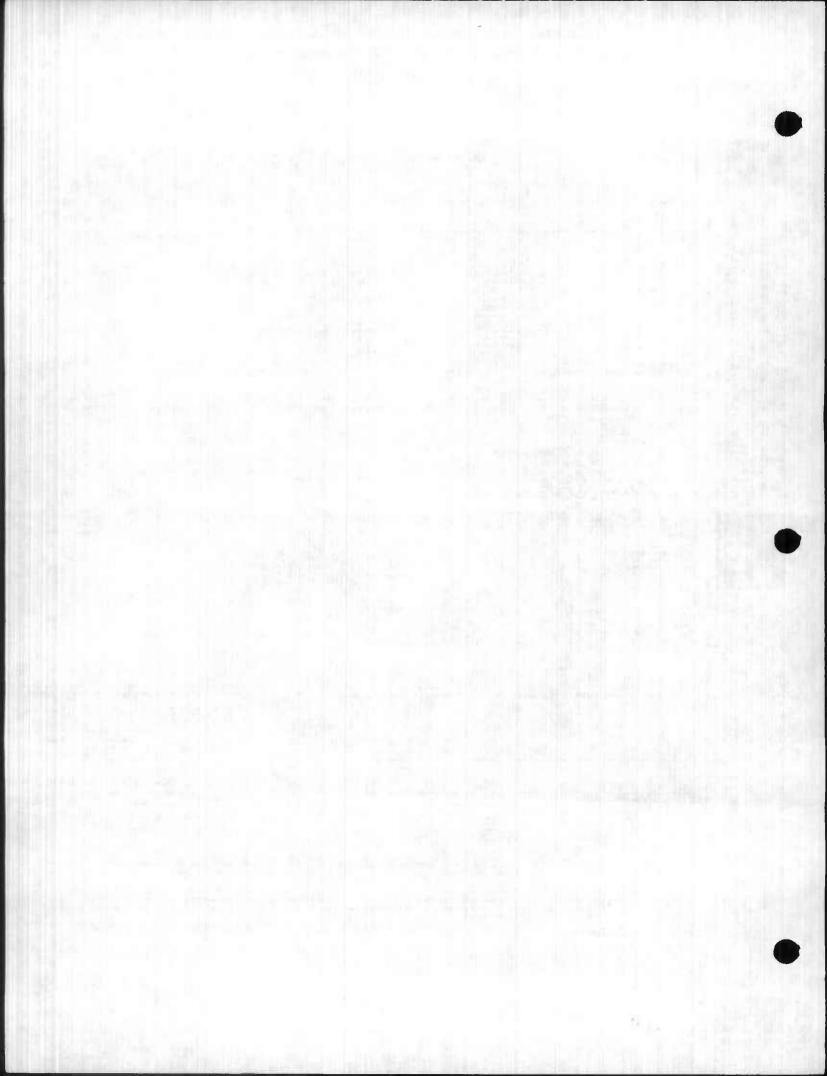
Sparks



State of Maryland / Department of Health and Mental Hygiene

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						Cer	rtificat	e of	Death			Reg. No.	0	
	14 (		1. Decedent's Neme (First, Middle, Las	et)			× 100				2. Dale of Dec	ath		3. Tima of Death
000	Physicia	_	JEANETTE ELAIN	E FREEMAN S	SCHWENT	Y					Septe	mber 7,	2000	11:20 A.M
	/Medica	-	4a Facility Name (If not institution, give		OCHWINI	71			4b. City, To	wn, or Li	ocation of Death			11.20 1111
	- Author		HOSPICE OF BALTIMO		RIST CI	ENTE	R		Tows	son		Baltin	ore (	County
_	Funeral		5. Social Security Number 6. S		(In yrs. lest b		If Under		If Under	24 Hrs.	8. Dele of Birt	h		ace (State or Foreign
	Director	-	101-46-3578 13 Usuel Residence of Decedent	□M 2ÅF	45	Yrs.	Months	Deys	Hours	Min.	Sept 12	2, 1954		York
	yland #		10a. Slele 10b. County		10c. City, Tov	vn or Lo	cation						10	Od. Inside City Limits
	Mar al	cto	Maryland Baltimon	re County		T	ousor	1						1 ☐ Yes 2 No
	with the	5	10e. Street and Number				10f. Zip		200			10g. Citizen of V		try?
	eath m 23	era	6318 Banbury Roa	12. Wes Decedent E	ver in IIS	13 1	Nas Decer	Gred with 6	239 Iisnanic Oric	nin? (Sn	ecity Yes or No	USA 14 Bacı	e - Americe	an Indian
21215-0020	urs a	by Funeral	1 Never Married 2 Merried 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Deles:		"	f Yes, spec	city Cube	Specify:	, Puerto	Rican, etc.)	Specify Specify	k, White, e	
5-0	natural',	Completed	15. Decedent's Ed (Specify only highest gre	ucation de completed)	166	(Give	dent's Usua kind of wo	rk done	duning most	of work	ina	16b. Kind of Bu	siness/ind	lustry
121	within then then	de l	Elementery/Secondery (0-12)	College (1-4or 5+	+)	'life. E	DO NOT u	se retired	d)					
7	Hygiene other the		17 Esthada Nama /First Middle ( ant)	2 yrs		10	ur Gu	11de	10 Motho	do Alam	o /First Middle	Museu		
and	o d a b	Be	17. Father's Name (First, Middle, Last)						15. Mothe	rsnam	e (First, Middle,	Meiden Sumem	ы)	
Maryland	d 2 should be th end Mental 7 is marked o traumatic eve	2	Richard Charles		1.0			101	Mar	cion	Hayes	Rogers or Town,	01-1-71-	0.41
Ma			19a. Informant's Name/Relationship (7	., .										
	1 an Heelt	1	David G. Schwendy  20e. Melhod of Disposition	(Husband	20b. Plece				Road,	Bal	Dele Dele	Marylar		
Baltimore,	855		1 Buriel 2 Cremelion 3		cemete	ery, cren	netory or o	ther plac	08)	- 1				
E	artmer ortant: Injury	-	4 Donellon 5 Other (Specify	-1	Acaci						9/12/200	00 Buffa	lo, N	New York
Ba	pemit. Pege Department Important: If any Injury or once.		21. Signature of Funeral Service User  Martin D	ausm		M:	itche	11-V		e1d		Home,		1212
			Martin D.  23a. Pert1. Enter the disease, or companion, or heart failure. List only	blicetions thet ceused tone cause on each line	the deeth. Do	nol enle	er the mod	le of dyir	ng, such es	cerdiec	or respirelory e	resi,	1	Approximele Interval Between
	Physician	4												Onsel end Deeth
	/Medical		Immediate Cause (Final disease or condition	A	stro	0	vit	nn	1 1 0	1 1	3CAL		30	Joans
	Examiner		resulting in deeth)	Ф.	Due to (or es e	conseq	uence of):		7	1	Braci		1	
Н	D &	ner							,					
	cate be executed physician and s the burial-transit	Examiner	Sequentially list conditions,	D	Due to (or as e	conseq	uence of):					94.00		
0,	e ex		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										-	
68760,	hysic the b	edical	thet initiated events resulting in death) Last	C	ue to (or es e	consequ	uence of):							
	E 04	2		4										
Box	death c	20		0										
0	the a	SIC	Pert II. Other significant conditions of	ontributing to death bul	nol resulting	in the ur	nderlying o	euse giv	en in Part I.		23b. Did	lobacco usa cor	itributs to	the causs of death?
<b>a</b>	that the death cer led by the attendir detached for use	/ Physician									10	Yes 2 No	3 Prob	pably 4 Unknown
of Vital Records,	8 5 8	Completed by										an autopsy med?	ava	ore sutopsy findings alleble prior to appletion of cause
Rec	has be	E									.0.	res 2 No		death?
a	delan: The		DE Was seen referred to modes!						00 01	-(D)	10		- '	Yas 2 No
Ž	5 00	0 00	25. Wes case referred to medicel examiner?  1 Yes 2 No	Hospitel: 1 Inpatien	2 ER/O	ulpatien	nt 3 DC	DA Oth	OF:		th <i>(Check</i> only come 5 ☐ Resid		er (Specify	Hospice
2		-	27. Manner of Death  1 Natural 5 Pending	28a. Dete of Injury (Month, Dey	Year) 28b.	Time of Injury	2	8c. Injur Wor	y at		28d. Describe	now injury occur	ed	
0	Attending r death. actor: After by the fune	38	2 Accident investigation				М	10	Yes 2 🗆	No				
Division	or Attending after death. Director: After I in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of fnjur building, etc.		erm, sire	eel, fector	y, office			28f. Location (: City or Tox	Street and Numb vn, State)	er or Rure	I Route Number,
		edical		ysician: To the best of liner: On the basis of e										
	the H		one)	and manner state		01 1119				50001				
	or viet	3	29b. Signature-and little of certifier	1).	1			a .	e number			29d. Date signer		
			1/ Mush	mykil	eg,	ins	0 .	0	29c	15		eften	ber	1,2000
	0		30. Name and address of person who o	completed ceuse of de	elh (Vem 23a)	(Type, I	Print)	d	milas	C	1 0	01.	u d	7,2000
	Stat		31. Dete filed (Month, Dey, Year)	3. Registrar	de Signeture	1	Noae	Ks	1000	/ا	. 650	Go.	- ( ()	-1-0/2
	Stat		CEP 1 5 2000	Denie	1	/	7							



State of Maryland / Department of Health and Mental Hygiene 00 29247

	Certificate of De	eath	Reg.	No.	
	1. Decedent's Name (First, Middle, Last)	2	. Data of Death Month	Day Ye	3. Time of Death
Physician /Medical	William J. STEWART		SEPT 12		2142
/Medical Examiner	4a Facility Nama (If not institution, give street and number)  4b. C	City, Town, or Loca		4c. County of D	
	SINAI HOSPITAL	BALTIMOR	T S	N/A	
	5. Social Security Number 8. Sex 7. Age (In yrs. last birthday) If Under 1 Yaar If	f Under 24 Hrs.   g	Date of Birth	9	Birthplaca (Stata or Foreig
1	97-38-8695 1 X 2 F 53 Yrs. Months Days H	Hours Min.	Month, Dey, Ye	947	OHIO
	Usual Residence of Decedent		EST EST		
	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Md. N/A BALTIMORE				1 Yes 2 No
200	10e. Street and Number 10f. Zip Code		10g.	Citizen of Wha	t Country?
-	5508 GIST AVENUE 2.21.	1.5		U.S.	Α.
	11. Marital Status 12. Was Decedent Evar in U.S. 13. Was Decedent of Hispa If Yes, specify Cuban, M	anic Origin? (Speci	fy Yas or No-		American Indian, Vhita, etc.
ı	1 Never Married 2 Married 1 Yes 2 No		carr, etc.;		AMERICAN
	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Specify:		Specify:	
ľ	15. Decedent's Education 16a. Decedent's Usual Occupation	on	16b	. Kind of Busin	ess/Industry
	(Specify only highast grada completed)  (Give kind of work done during life. DD NDT use retired)  Elementary/Secondary (0-12)  Collega (1-4or 5+)	ing most of working			
	12TH COOK		R	ESTAUR	ANT
I		8. Mothar's Name (	First, Middle, Mai	iden Sumeme)	
	SHERMAN H. STEWART	ERNESTI	NE LIN	COLN	
	19e. Informent's Name/Reletionship (Type, Print)  19b. Mailing Address (Street end	d Number or Rural I	Route Number, Co	ity or Town, Ste	te, Zip Code)
	DIANE H. STEWART (WIFE) 115 MAYBIN C	CIRCLE C	WINGSM	ills .	md. 21117
	20a. Method of Disposition 20b. Plece of Disposition (Name of				or Town, State
	1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State cametery, cremetory or other pleca)			0000	
	4 Donation 5 Other (Specify) GREEN MOUNT CREM		SEPT. 15	,2000	BALTO, MD.
	21, Signature of Funeral Service Ucensee 22, Name and Address of CALVIN B.	SCRUGO	S FUNE	RAL HO	ME
	DeMadere / Acruse 1412 E. P	PRESTON	ST. BA	LTO, MD	. 21213
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, so shock, or heart failure. List only one cause on each line.	such as cardiac or	raspiratory arrest,	,	Approximate Interval Between
					Onset and Death
	Immediate Cause (Final disease or condition Acute Myotombias is	longtin			imelute
	Immediate Cause (Final disease or condition resulting in death)  a. Acute Myotconduce in Dua to (or as a consequence of):				
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	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.				
	that initiated events				1
Medical Examiner	resulting in death) Last				
	d				
	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in	in Part I	23h Did toha	cco usa contri	buts to the cause of death
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combiered by			24a. Was an a		4b. Wera autopsy findings
1			performed		available prior to completion of cause
				1	of death?
			1 ☐ Yes	No	1 Yes 2 No
	examiner?	8. Place of Deeth	(Check only one)		
		4 Nursing Home	e 5 Residenc	a 8 Other (	Specify)
ı	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28c. Injury at Work?	t 28	d. Describe how	injury occurred	
ı	2 Accident investigation M 1 ☐ Yes	s 2□No			
	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify)	28	St. Location (Street City or Town, S		or Rural Routa Number,
ı				7.35	
carcal cel micanon:	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, of				
	(Check only one)  2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion and manner stated.	ion, death occurred	at the time, date	and plece, and	que to the cause(s)
	29b. Signature and IIII of certifier 29c. License nu	umber	29d.	. Date signed (A	Aonth, Dey, Year)
1	bullen mus D25	72 "	9	hulo	
		, 0 3 %	1	1,4100	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	H. A.	PALL	- MO 21	2001
	31. Date filed (Month, Day, Year) 192 Registrates Signature Aparts	W /400	047/	100	
r	31. Date filed (Month), Day, Year) SEP 1 5 2000  SEP 1 5 2000				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacadent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day ELIZABETH LAURA TODD SEPTEMBER 11 2000 8:31am 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER TOWSON 8. Date of Birth (Month, Day, Year)
Dec. 14,1921 If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1□M 2XJF Hours 78 219-18-1279 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Baltimore County/Towson 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 916 Dunellen Drive 21286 USA 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes ≥ 2∑ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Baltimore County (Give kind of work done during most of working life. DO NOT use retired) Elemantary/Secondary (0-12) College (1-4or 5+) Dept. of Education Teacher/Kenwood High School 12 yrs. 6 yrs. 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ernest John Stratmann Verona Hildesheim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) A. Morris Todd, Jr. (Husband) 916 Dunellen Drive Towson, Md. 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXX Burial 2 Cremation 3 Removal from State

Oak Lawn Cemetery

Due to (or as a consequence of)

Due to (or as a consequance of):

Due to (or as a consequence of)

1 Inpatient 2 ER/Outpatlent 3 DOA

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

**Physician** 

Physician

/Medical

Examiner

10a. State

4 Donation 5 Other (Specify)

tmmediata Causa (Final

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last

1 Yes 2 No

5 Pending Invastigation

6 Could not be determined

1 Natural

2 ☐ Accident 3 Suicide

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29a. Certifier

disease or condition resulting in death)

Director

by

Completed

**Funeral** 

Director

28a-f show

7 is marked other than "naturel", or items 23a or 28a-1 shot traumatic event, the Marical Examiner must be notified at

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Examir Physician/Medical by Completed Be 2 Certification: Medicai

Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 25. Was cese rafarred to medical axaminar? 27. Manner of Death

and Box 68760. certificata be the atter jo P.0. the 2 signed b Records, peed page 2 Division of Vital Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifica

To the Mospital within 24 hours a To the Funeral Completaly filled

Registrar

DAVID E. KATLAN, MO 31. Date filed (Month, Day, Year) SEP 1 5 2000

29b. Signature and title of certifier

Bud G. K 30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

32. Registrar's Signatura

souks

28c. Injury at Work?

29c. License number

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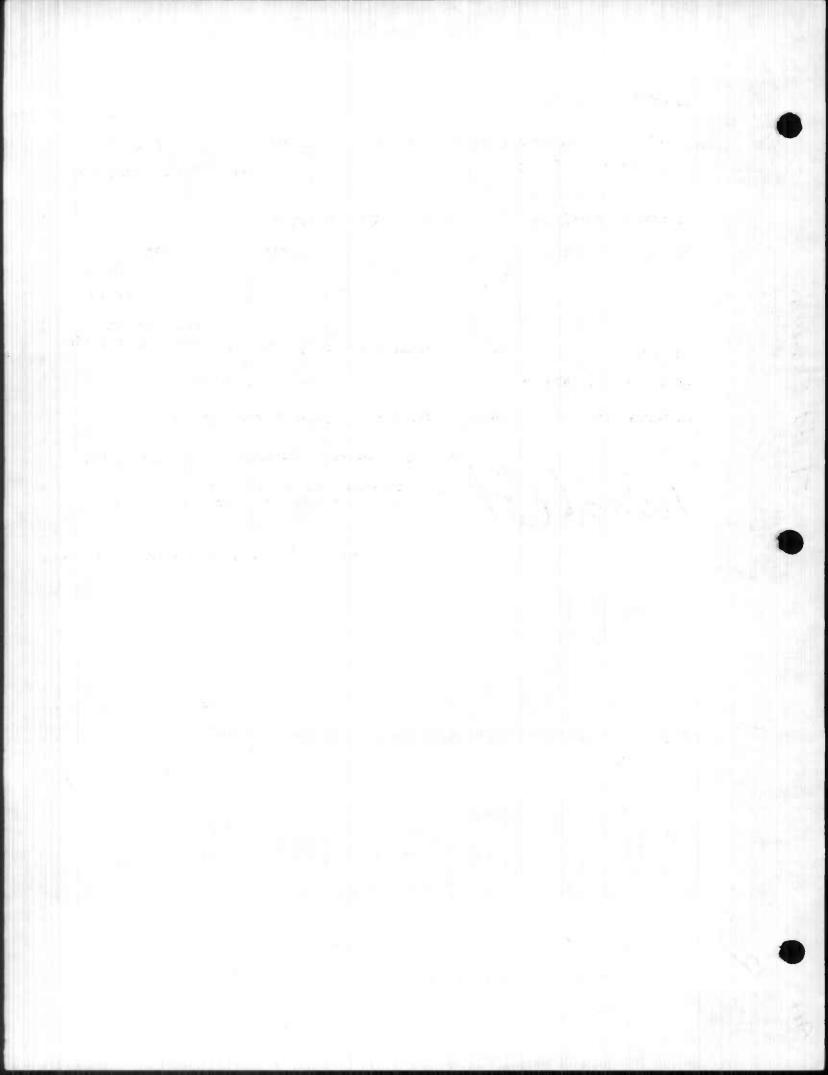
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9-14-2000 Baltimore, Md. 22. Name and Address of Facility
Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 sed the death. Do not enter the mode of dylng, such as cerdiac or respiratory arrest, Onset and Death obstructive pulmonary disease 5 years 23b. Did tobacco use contribute to the cause of death? 2□ No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 26. Placa of Daath (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physicien: To the best of my knowledga, death occurred at tha tima, data and place, and due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, data and place, and due to the cause(s) and manner stated.

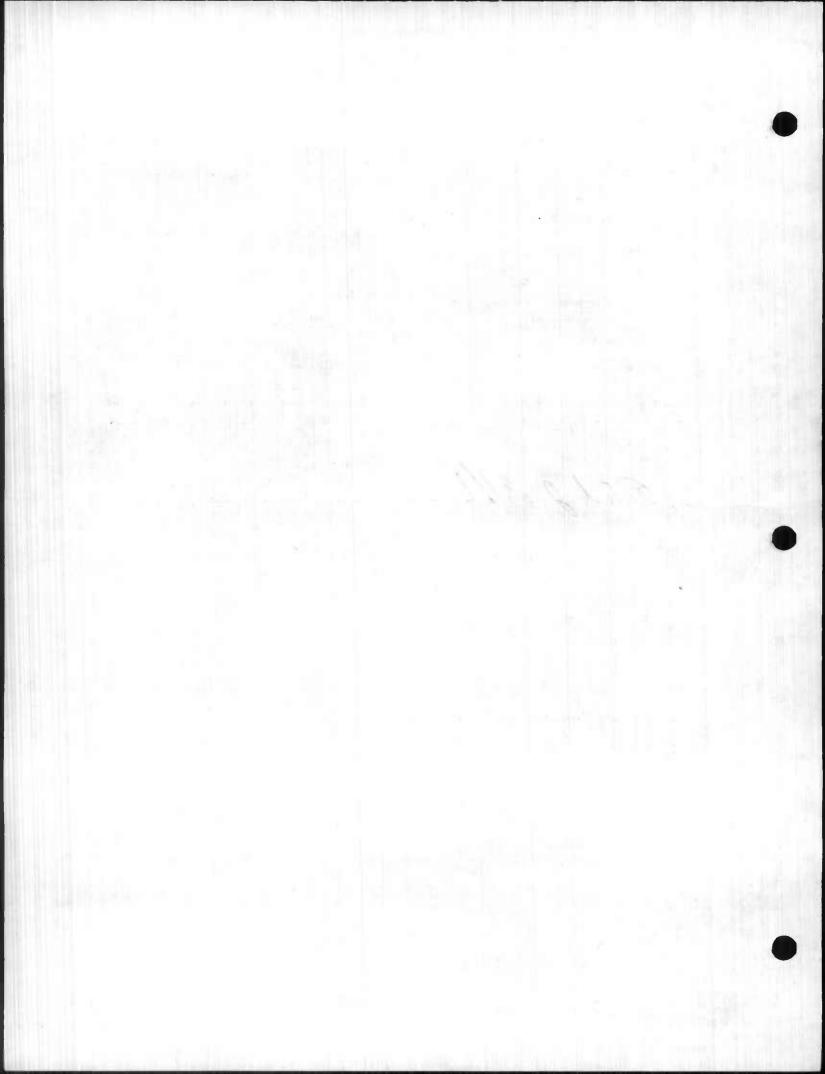
> 29d. Date signed (Month, Day, Year) September 11, 2000

6704 N. CHARLES ST., ROOM 3883, BALTIMURE MO 21204



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Jeanette C. Toomey Sept. 10 2000 12:15pm /Medical 4b. City. Town, or Location of Deeth 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🖾 F 155-01-5754A 82 Sept. 18,1917 Director Pennsylvania Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits NYes 2 No Directo Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 2619 Point Lookout Cove Nerna 23a 21401 USA Funeral 12. Was Decedent Evar in U,S.
Amued Forces?
fEfYas 2 No
If Yas, Giva
Year or Datas: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Nevar Married 2 Married Maryland 21215-0020 b 1 Yes 20XNo Specify: Specify: White 3€Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 5+ Teacher Education 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 te merked or any Injury or other traumatic eve Donald Mclean Emma Helper 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 5474 Greenock Road, Lothian, MD 20711 Patricia A. Adams (Daughter) Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 09/12 1 ☐ Burial 2XXCramation 3 ☐ Ramoval from Stata Metro Crematory 4 ☐ Donation 5 ☐ Othar (Specify) 2000 Baltimore, MD 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 21. Signature of Euperal Service Licens 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part 1. Entar the disaase, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical Examiner Jacker Sequentially list conditions, if any, leading to immadiata cause. Enter Undarlying Cause (Diseese or Injury that initiated evants rasulting In death) Last 68760. Dua to (or as a consequence of): Don Physician/Medical the Box law requires that the death P.O. 1 Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown artery desease Records, Be Completed by 8 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 100 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No certificate of Vital Hospital or Attending Physician: 25. Wes casa rafarred to madical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Mennar of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? After Division 5 Panding invastigation 1 Neturel s after death. 1 | Yes 2 | No 2 Accidant 3 Suicide 6 Could not be 281. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of partifier 29d. Date signed (Month, Day, Year) 9/14/80 18809 who completed causa of death (Item 23a) (Type, Print) annapolis 401 31. Date filed (Month State Registrar



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director To Be		anner of Death		28a. Date o (Month	f Injury n, Dey Year)	28b. Time of Injury	28	Bc. Injury Work			d. Describe h	ow Injury occu	rred	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 11 2000 William Aubry Taylor Sept. 3:35 PM /Medical 4b. City. Town, or Location of Deeth 4s Facility Name (If not Institution, give street and number) 4c. County of Death **Examiner** Oak Crest Village Parkville Baltimore If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1QM 20 F Days Hours Yrs. 85 Director 217-03-1667 Sept. 16 1914 Virginia Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1□Yes 2QNo Director Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 mant be 238 8800 Walther Blvd. BT 1212 21234 Funeral USA 12. Wes Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indien, Black, White, etc. 11. Merital Status 1 Never Married 2 Merried 1 X Yes 2 No If Yes, Give Year or Dates: 141-146 þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 12 n/a Grocery Store Manager Supermarket 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Sumame) Lawrence Taylor Flora Baker 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Code) Helen H. Taylor/wife 8800 Walther Blvd., BT 1212, Parkville, MD 21234 tant: If Hem 27 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremetion 3 ☐ Removal from State Druid Ridge Cemetery 9/14/00 4 ☐ Donation 5 ☐ Other (Specify) Pikesville, MD 22. Name and Address of Facility Lemmon Funeral Home Michael Flagte 10 W. Padonia Rd., Timoniur

23a. Perff. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. 10 W. Padonia Rd., Timonium, MD 21093 Approximate Interval Batween Onset and Deeth **Physician** ARKINSO N'S 11SEASE /Medical Immediate Cause (Final disease or condition rasulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yas 2 No 3 ☐ Probably 4 ☐ Unknown CHRONIC RENAL INSUFFICIENCY Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? CORONARY ARTERY DISEASE 2 NO 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Homa 5 Rasidance 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending Investigation death. t ☐ Yas 2 ☐ No Director: / 281. Location (Street end Number or Rurel Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and manner as stated.

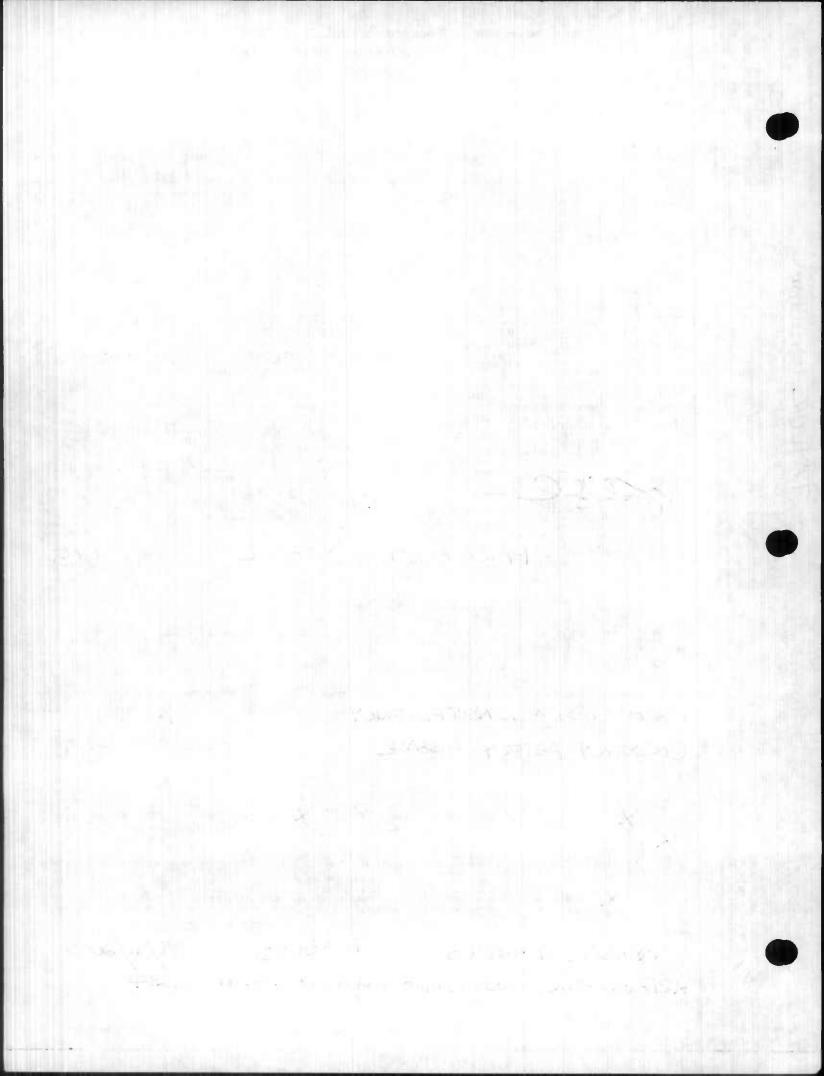
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a Certifier 29c, License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boltmare MD KRFaulknermo 8800 Walther Bud,

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Registrar

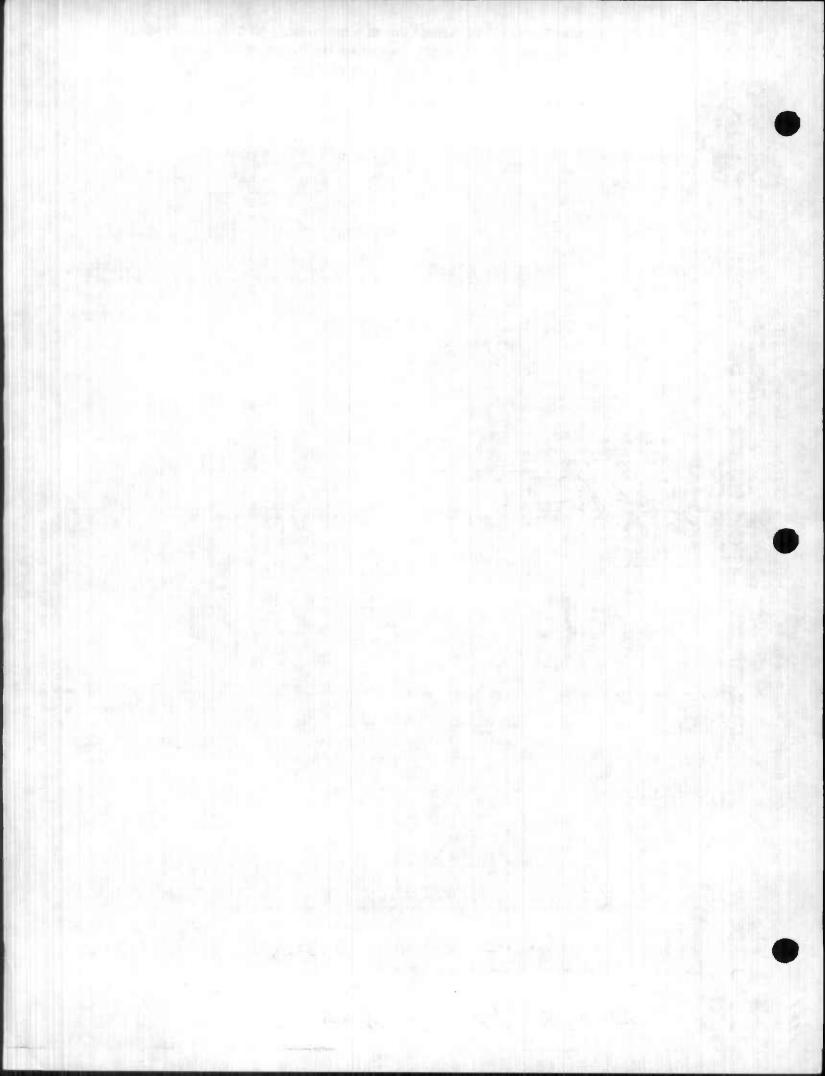
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32. Registrer's Signeture



	1. Decedent'a Nama (First, &	Middla, Last	)				- 11			2. Data of De			3. Time o
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neral ector	5. Social Security Number 217-14-2533	6. Sa:	x ]M 2∭ F	7. Aga (In yrs	i. lest birthda; 32 Yrs.	y) If Under 1 Months	Yaar Days	If Under Hours	Min.	8. Deta of Bi (Month, Di June 1	rth ay, Year) 1, 1918	9. Birthi Cou Mar	place (Stata ntry) yland
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o Be	James L. Howa		r.							Watts			
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	Mr. Harry E.	Smith	- Son		880	2 Alnw	ick	Road	Par	kville	, MD 2	1234	
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á	21. Signature of Funeral Ser	rythythynn	00			22. Nama and				1 D:			
8	1 State	Dan				_	-				ctors, I		21133
00	Immediate Cause (Final			each tine.		ntar tha moda	or ayın	g, such as	cardiac o	respiratory	arrast,	1	Approxima intarval Be Onsat end
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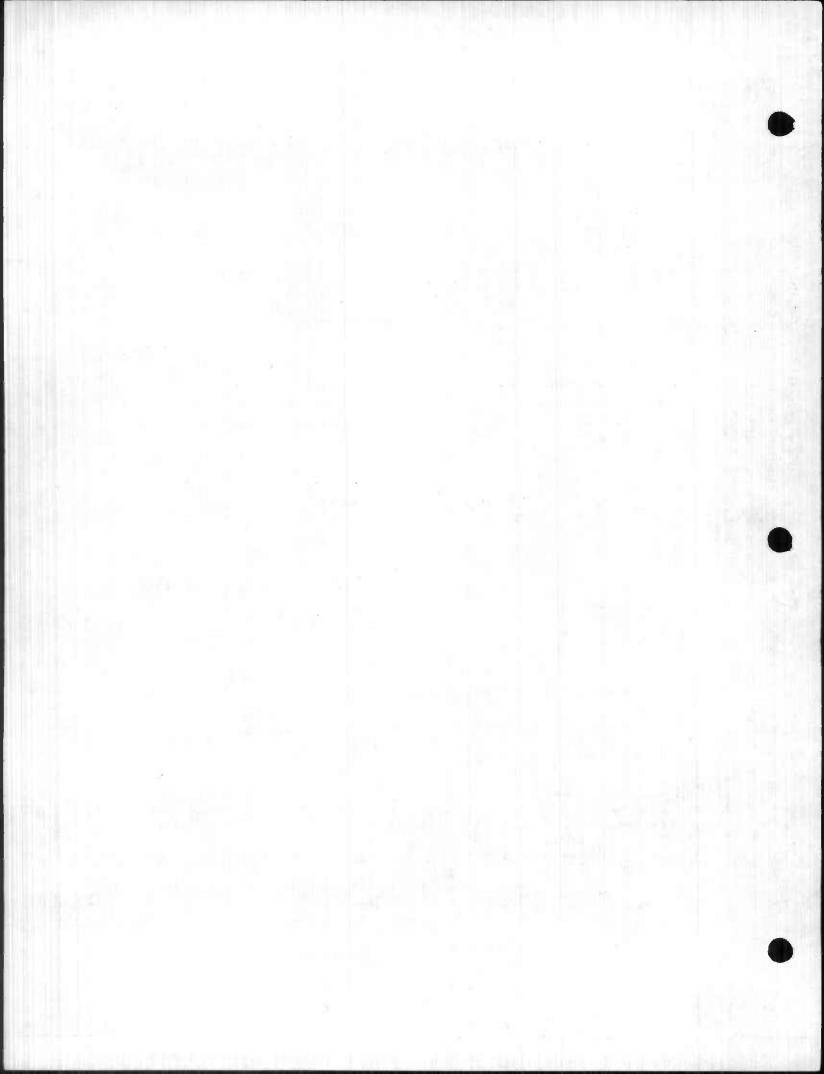
ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 6:20 AM Andrew Jules Vann September 13, 2000 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Ritchie Hospice Baltimore If Under 1 Yee If Undar 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** Hours Months Days 10M 20 F 213-36-3846 60 Yrs. Director August 1, 1940 New York Usual Residence of Decedent the Manyland 10h Count 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Maryland Baltimore Arbutus 1 Yas ZE No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 1056 Downton Road 21227 United States Herns 23a Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 △Yes 2 □ No 1979 If Yes, Give Yaar or Dates: 1980 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Bleck, White, etc. 11 Marital Status 1 Never Married 2 Married 1□ Yes 2☑No ò aitimore, Maryland 21215-0020 Specify Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Machinist Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumama) Be of Health and Mental Item 27 is marked o Pages 1 and 2 should be Constantine Anthony Vann Sylvia Coven 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Joyce A. Vann 1056 Downton RD. Arbutus, MD. 20b. Place of Disposition (Nama of camatery, cremetory or other placa) 20e. Method of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removel from State Glen Haven Cemetery 09/16/00 Glen Burnie Maryland 4 Donation 5 □ Other (Specify) Ambrose Funeral Home INC. 1328 Sulphur Spring Rd Funaral S Arbutus, Maryland 21227 23a. Part1. Enter the disease, or complications that caused to shock, or heart faiture. List only one cause on each line th. Do not enter the mode of dying, such as cardiec or respiretory errest, Approximate Interval Between Onset and Death **Physician** tmmediate Cause (Finat disease or condition resulting in death) /Medical Psophagea mo Examiner ancer to brain Examiner physician and is the bunal-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last be exec Physician/Medical Due to (or as e consequença of) ŏ been signed by the a Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown à 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed 1 Yas 2 No 1 Yes 2 No certificate Division of Vitai director, 25. Was case referred to medicat examiner? Be 26. Place of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence DOther (Specify) NOST N CC 1 Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Tima of 28c. tnjury at Work? 28d. Describe how injury occurred Certification: After PÉ Natural 5 Pending Invastigation death. 1 Yas 2 No or Attendation of the order of 2 Accident 3 Suicida 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida To the Hospital or within 24 hours after To the Funerel Direcompletely filled in b 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Wolf S 32. Registrer's Signeture 600 31. Data filed (Month, Day, Year) State SEP 1 5 2000 Peren Registrar **DHMH 16 Rev 6/95** AAT A C AAA

**ORIGINAL** 



			Certificate of	f Death	Reg	. No.	0 29254
n	Decedent's Nama (First, Middle, L.	BEVERLY	WALLACE		2. Date of Death Month		3. Time of Deeth 9:38 P.M.
ŀ	4e Facility Neme (If not institution, gi	ve street and number)		4b. City, Town, or Lo	SEPTEMBER ocation of Death	4c. County of	
١	FRANKLIN SOLLARA	E HOSPITAL CENT	TER	ROSEDAL			IMORE
	415-22-5555	Sax 7. Aga (In yrs. les 1□ M 2⊠ F 53			8. Dete of Birth Month, Dey, Y Oct - 31 1	946	Birthplace (State or Foreign Country) Cenneessee
⊢	Usuel Residence of Decedent  10a. Steta 10b. County  Md Baltin		Town or Location Mid	dle River			10d. tnside City Limits 1 ☐ Yes 2 ☑ No
	10e. Street and Number	Drive	10f. Zip Code	21220	10g	Citizen of Wh	at Country?
	11. Merital Stetus  1 Never Merried 2 Merried	12. Wes Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2X No If Yes, Give	13. Wes Decedent of If Yas, specify C	of Hispenic Origin? (Spuban, Maxican, Puarto	ecify Yas or No- Rican, etc.)	Bleck,	Amarican Indian, Whita, atc.
	3 Widowed 4 Divorced	Yaar or Datas:					White
	15. Decedent's E (Specify only highest gi Elementary/Secondery (0-12) 12th		16a. Decedent's Usual Occ (Give kind of work do: life. DO NOT use ret Homemaker	cupation ne during most of work ired)	ing 16	b. Kind of Busi OWn l	
-	17. Fathar's Nama (First, Middla, Las James Fick	v	Homemanez	18. Mother's Nemo	e (First, Middle, Ma		
	19e. tnformant's Name/Reletionship Victor Wallace		19b. Mailing Address (Stree 135 Dihed			City or Town, Si	
-	20a. Method of Disposition  1 Buriel 2 Cremetion 33  4 Donetion 5 Other (Spec	20b. Pie	ce of Disposition (Neme of netery, cremetory or other p ertsonMemoria	plece)	Deta 20	c. Location - C	ity or Town, State
	23a. Parti. Enter the disease, or con shock, or heert failure. List only	polications that caused the death one cause on each line.	300 Ma	ly Funeral ce Ave. Ba	Ltimore M	d 21221	Approximate tnterval Between Onset and Deeth
	Immediata Cause (Final disease or condition resulting in deeth)	0.	ULAR ARRI	HYTHMIA			
l			KALEMIA				
	Sequentially list conditions,	D	es e consequence of):				
	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. RENA Dua to (or a	L FAILURE is a consequence of):		- 44 / 1		
		d					1
ı	Pert II. Other algoriticant conditions  CHRONIC OBSTRUCT			given in Pert I.			ributs to the cause of death?  B Probably 4 Unknown
	EMPHYSEMA				24a. Was an a		24b. Were eutopsy findings available prior to completion of cause of deeth?
	CONGESTIVE HER	ART FAILURE			1 ☐ Yes	2 00	1 Yes 2 No
1	25. Was case referred to medical axaminer?	Hospitat:		Other	h (Check only one)		400004
-	1  Yes 2 No  27. Manner of Death  1  Natural 5  Panding 2  Accident invastigatio	28a. Date of Injury (Month, Dey Year) 2	8b. Time of 28c. tr	4 ☐ Nursing Ho	ome 5 Residence 28d. Describe how		
2	2 Accident invastigation	20			281 Location (Stre	et and Number	on Dural Davida Alumbar
cel unication:	3 Suicide 6 Could not l 4 Homicide determined		e, farm, street, factory, offic	20	City or Town,	State)	or Rural Route Number,
	4 ☐ Homicide determined	286. Place of injury - At nom	edge, death occurred at the	time, date and plece,	City or Town,	State) se(s) and mani	ner as stated.

DHMH 16 Rev 6/95

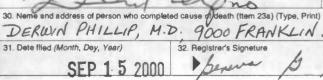
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

WALLACE, BEVERLY

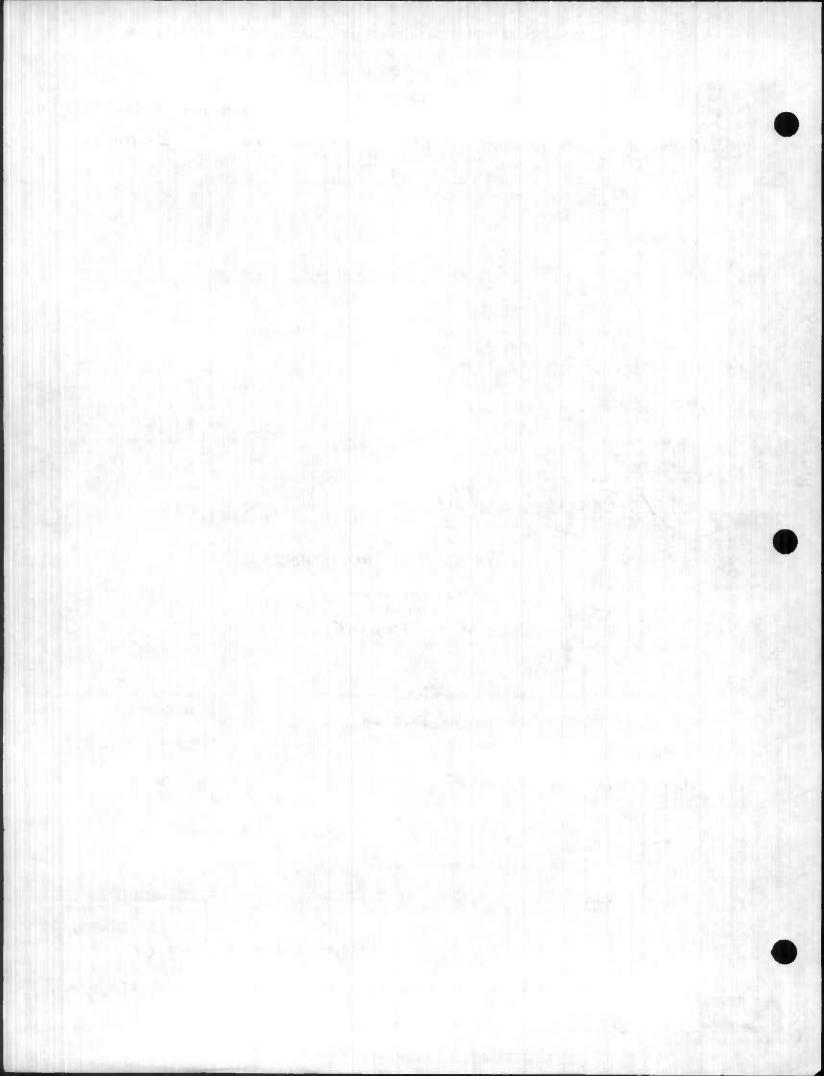
State Registrar

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SQUARE DRIVE, BALTIMORE, MD 21237 bouts

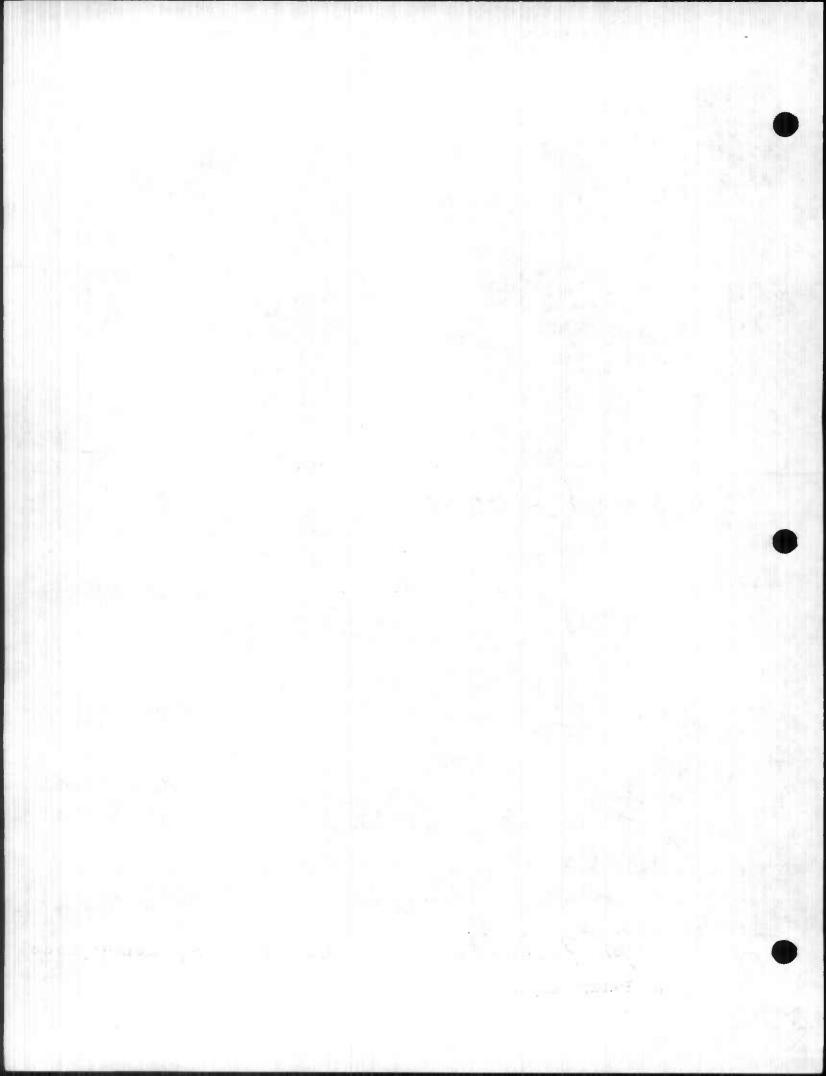
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State of Maryland / Department of Health and Mental Hygiene 0 0 29255

									Death			Reg. No.			
	1. Decedent's Nan	na (First, Middl	la, Last)		eloniki						2. Data of De		Vaar		Tima of Death
ian cal	KA	THY				WIS	E-EL				SEPTEM	BER (	09 200	00	16:00
ner	4a Facility Nama	(If not institution									ecation of Death	4c. Co	ounty of Dea		
	5. Social Sacurity		6. Sex	11001		s. last birthday	v) If Unda	ar 1 Yaar	If Undar		8. Data of Bir (Month, Da	th	9. Bir	NA	(Stata or Fore
	217-66-	5523	101	y 2□ F	41	Yrs.	Months	Days	Hours	Min.	(Month, Da 04-27		Co	ountry)	ID
	10a. Stata	10b. County	,		10c.	City, Town or I	Location	Trans.						10d. li	nside City Lim
Director	MD	1	NA		Ва	ltimo	re							x	Yas 2 1
	10e. Street and Nu	umber					10f. Z	ip Code				10g. Citizer	n of What Co	ountry?	
	2225 C	rleans	s St	reet			2	1231				US	SA		
of a more	11. Marital Status  1 Nevar Mar		ried	Armed F	2 No iva	U,S. 13			lispanic Or an, Maxica Specify:	igin? (Spi i, Puarto	ecify Yas or No Rican, atc.)		Raca - Ama Black, White		
ŀ	0 = 111001140	15. Decedan			Jaias.	16a. Dec	edent's Us	ual Occur	pation	100		16b. Kind	of Businass		
navaldillon.	(Spe	cify only higha	st grada	complated)	1-4or 5+)	(Giv	a kind of w DO NOT	vork dona usa retire	during mos	t of work	ing				
	High Sc		ad	NA	1-401 5+7	Day	Car	e Pr	ovid	er		in h	home		
	17. Father's Nema	(First, Middle,	Last)						18. Moth	ar's Nem	e (First, Middle	, Maidan Su	imame)		
	Albert	Thomas	s, S	r.					Mar	У		Sı	mith		
	19a. Informant's Michel										al Route Numb Baltin				-
	20a. Mathod of Dis	sposition			206	. Place of Disp cematary, or	position (N	ama of	1		Deta	20c. Loca	tion - City or	Town,	Stata
-	23a. Parti. Enter- shock, or he	the disaasa, or ert tailure. List	r complica t only one	itions that cause on	caused the da	iath. Do not a	WM . C	. Mar	ch F	H 1	ltimor 101 E. or raspiratory a	Nor		ent	1e proximata
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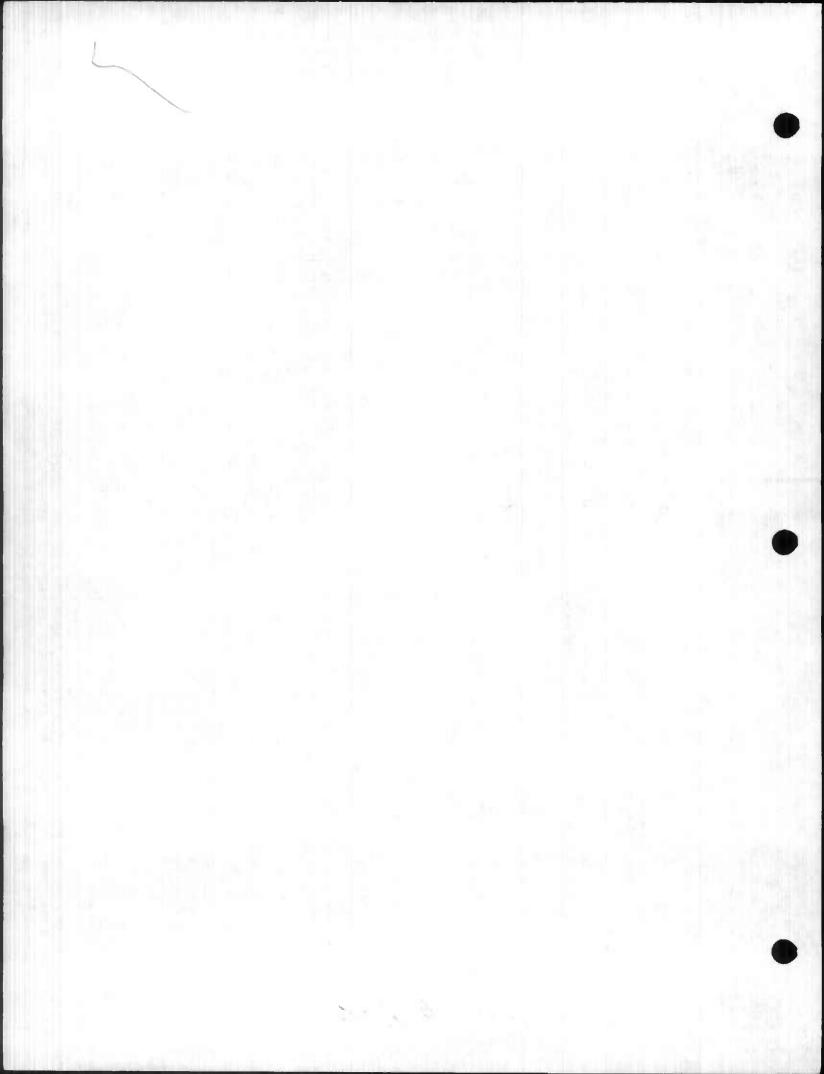
DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene 00 29256

			Certifica	te of Death	R	g. No.	27200	
Physician	Decedent's Nama (First, Middla, Last)     EM M A	E	WIL	LIAMS	2. Data of Deat Month SEPTEMB	Day	Year 4:22	
/Medical Examiner	(111/20	ITAL CE	NTER		Mo RE	4c. County of	N/A	o i a a
Funeral Director	5. Social Security Number 6. Sex 220 - 12 · 825 1	7. Age (In yrs.	Yrs. Month			Year) 25	9. Birthplece (State or Fore Country)	ngn
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flar death with the Maryls r theme 23e or 28e-1 sho ther must be notified at Funeral Director	3405 PARK LAW!	U AVENUE	10f. 2	21213	1	0g. Citizen ot W	Mat Country? USA	
urs aftar Mr. or tto Framme by Fur	11. Marital Status  1 Nevar Married 2 Married 3 Widowed 4 Divorced	I2. Was Decedant Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		edent of Hispanic Orlgin? ecify Cuban, Mexican, Pur 2 No Specify:	(Specify Yes or No- erto Rican, etc.)		- American Indien, k, White, etc.	
n 72	15. Decedent's Educ (Specify only highast grede Elementery/Secondery (0-12)  A 11  17. Father's Name (First, Middle, Last)	cation completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of life. DO NOT PATIENT	vork done during most of w use retired)  ASSISTANT	vorking	16b. Kind of Bu  NURSIA  Meiden Sumema	IG HOME	
2 should be and Menta is marked surretic av	JAMES HARRIS  19a. Interment's Name/Relationship (Ty)		0 1 0-	ss (Streat and Number or		, City or Town,		
age ant o	CELESTINE PARKI  20a. Method of Disposition  1	amoval from State	Place of Disposition (A cometery, crematory of G MEMORIA	r other plece)	Date	20c. Location -	City or Town, State  STOWN, MD	
permit. Pages 1 a Department of Har Important: if item any Injury or othe page.	21. Signature of Funeral Service License		22. Name VAUGH	and Address of Facility  N. C. GREEN  BALTO. NATL'	UE FUNE	LAL SE	RVICE	
Physician /Medical Examiner	23a. Part1. Enter the disease, or complishook, or heard tailure. List only on Immediate Cause (Final disease or condition resulting in death)	CEREB	LAL or as a consequence o	HEMORR	MAGE		Approximate Interval Between Onset and Death	1
leath certificate be executed attending physician and for use as the bunst-transit claryMedical Examiner	Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (d	or as a consequence of		ACC TYE	N (	2 947	. 7
death ed for u	Part II. Other significant conditions con	tributing to death but not ras	sulting in the underlying	cause given in Part I.	23b. Did to	ebacco usa con	ntributs to the cause of de	ath?
v requires that the death cerbeen signed by the attending should be detached for use leted by Physician/N	14 YPERTENSI				1 D Y	88 2 No	3 Probably 4 Unkr	nown
9 20 0	DIABETES	MELLIT	US		24a. Was a perfori	n autopsy med?	24b. Were sutopsy tindin- svailable prior to completion of cause of death?	
cartificate has rector, page 2			13.55		1 U Y		1 ☐ Yes 20XNo	
E 10 E	25. Was case reterred to medical examiner?  1 Yes 2 No  27. Manner of Deeth  1 Naturel 5 Pending 2 Accident Investigation	ospitat: 1 Inpatient 2 28a. Dete of thirty (Month, Dey Year)	28b. Time of Injury	Other:	g Home 5 Reside	ence 8 Othe		
To the Hospital or Attanding Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral of the f	3 Suicide 6 Could not be determined	28e. Place ot Injury - At h building, etc. (Speci	ome, farm, street, tact	ory, office	28f. Location (S City or Town		er or Rural Route Number,	
n 24 hour n 24 hour ne Funera pletely fill.	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	Iclan: To the best of my known: On the basis of examination and manner stated.	owledge, death occurrent ation and/or investigeti	ed et the time, date and ple on, in my opinion, deeth o	ece, end due to the courred at the time, d	ause(s) and ma ete and place, a	nner as stated. and due to the cause(s)	
To the within To the comp	29b. Signature and title of pagallet	9642		P13132		FOREM (	Month, Day, Year)  LR & 200	0
1	30. Nama and address of person who co		m 23a) (Type, Print)	SOUTH BAL	HANOVER	2 STR	EET	
State	31. Date tiled (Month, Day, Year)	32. Registrar's Sign	B. Soo	uls/				

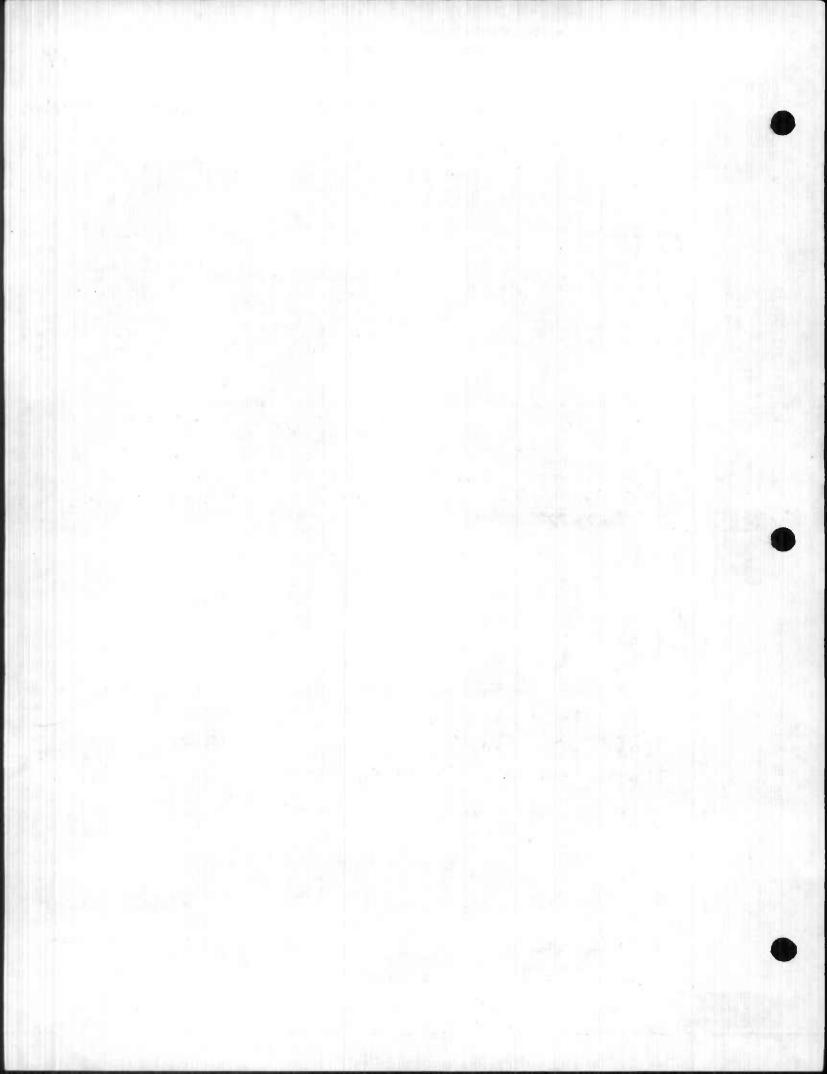
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State of Maryland / Department of Health and Mental Hygiene O

				Otato of Wie	il ylallo /	Certific		Death	vicinairiy	Reg. No.	2	9257
			1. Decedent's Neme (First, Middle, Last)						2. Date of De	eath	Vans	3. Tima of Death
1	Physicia /Medica	_	Shirley	1-		1/4	105	T'N	Month Aug	2Z	Year	1-19 PM
	Examine		4e Fecility Name (If not institution, give s	treet and number)				4b. City, Town, or L		h 4c. County		
			Planemar V.	'ew 1	LUKSE	ne 140	1416	IVIT BY	RV	COM	12120	6
	Funeral		5. Social Security Number 6. Sex	7. Age M 3/2 F	(In yrs. last	birthday) If U	nder Year		8. Date of Bi	th sy, Year) 5,1931	9. Birthp	lace (State or Foreign
	Director		215-11-8631	m 25	68	Yrs.			Oct 2	5,1931		Virginia
	Para Ra	1	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Location					1	0d. Inside City Limits
	Mary Fah	ō	Maryland Carro	11				Hampstea	ad			1 Yes 2 No
	1 28e	9	10e. Street end Number			10f.	Zip Code			10g. Citizen of W	hat Cour	itry?
	7 with	Funeral Director	1544 N. Main Stree	t		15.75		21074		Ţ	JSA	
	deat deat	ner	11. Marital Status	2. Was Decedent E Armed Forces?	ver in U,S.	13. Wes D	ecedent of	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No	14. Rece	- Americ	an Indian,
21215-0020	urs e	ρ Ω	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 N If Yes, Give Year or Dates:	o		s 2 No		rican, etc.,	Specify:	F 76	nite
5-0	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	1	6a. Decedent's l	Usuel Occu	pation	kina	16b. Kind of Bu	siness/Inc	dustry
121	within one.	du L	Elementery/Secondary (0-12)	College (1-4or 5-	+)			during most of work ed)		Owm	Home	2
	e filed withing it Hygiene.		10 17. Father's Name (First, Middle, Last)			H	ousew.	_	- 4577A BAS-A-M-	, Maiden Sumamo	77.	
Maryland	Sar bo	o Be	Unknown						n Kesne:		9)	
7	d 2 should be f h and Mental i 7 is marked of traumatic eve	ř	19e. Informant's Name/Relationship (Typ	ne Printl	1	9h Mailing Add	race (Strae	and Number or Rus			State Zin	Code
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re,	-155	1	20a. Method of Disposition		20b. Place	of Disposition (	(Neme of	acel	Dete	20c. Location -	City or To	wn, State
E	4 - 4	-	1 ☐ Burial 2 ☐ Cremetion 3 ☐ Re 4 ☐ Donetion 5 ☐ Other (Specify)	emovel from State		pstead (			8/30	Hamps	tead	, MD
Baltimore,	Printe Printe		21. Signeture of Funeral Service License	1 1007	23	22. Nam	e end Addr	ess of Fecility	Eline	Funeral 1		
m	O o o o		xteau (	U Til	ne	9:	34 So	uth Main				MD 21074
		7	23a. Pert1. Enter the diseese, or complic shock, or heart failure. List only on	ations that caused	the death. C	o not enter the	mode of dy	ing, such es cardiac	or respiratory	errest,	- 1	Approximeta Interval Between
	Physician										1	Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition	MYC	CARD	TAL	INF	PARCTI	No		(	me day
			resulting in death) a		Due to (or as	a consequence	of):				1	
	b is .	Examiner	_ b			BNSI					i	Jean
_6	fficeta be executed physicien and as the buriel-transit	Xar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	, (	Due to (or as	e consequence	of):				i	
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	W 170 170 170 170 170 170 170 170 170 170	edical	resulting in death) Last		NO TO (OF as	a consequence	OI).					
Box	attending for use as	2	d.									
	the death cert y the attending sched for use	CIE	Part II. Other significant conditions cont	ributing to death bu	t not resultin	g in the underlyi	ng cause g	iven in Pert I.	23b. Dld	tobacco uee con	tribute to	the cause of death?
P.0	and the de detached	rnysician/M	HURED I DERK	MARC					10	Yee 20 No	3 Pro	bably 4 Unknown
	the de d	2	11 DESCIPING	MIAS								
Orc	been s	Completed	SENILE DEM	IENTIA					24e. Wes	en autopsy ormed?	av	are eutopsy findings alleble prior to mpletion of cause
Sec	hes b	di.	Chronic obs		20.	Imanan	. D	me Re			of	death?
a F	cate he			1 AUCI IVE	- 1 -	VII ( 0 100)	7 2	7,000	10	Yes 2 PNo	1[	Yes 25 No
of Vital Records,		ן פ	25. Wes case referred to medical examiner?	ospitel:				26. Place of Dee				
	h sip	0	1 Yes 2 YNo 27. Manper of Death	1 ☐ Inpatier 28a. Date of Injun		Outpatient 3D	DOA	4 Mursing H		how injury occurr		y)
on	ding h. After fune	IOI	1 Metural 5 Pending investigation	(Month, Day		Injury M	28c. Inje	ork? ]Yes 2 □ No	200. 0000.00	tion injury coods.		
Division	or Attanding after death. Director: After In by the fune	20	3 Suicide 6 Could not be	28e. Place of Inju		, farm, street, fee	ctory, office			Street and Number	or or Rure	I Route Number,
ă	after A Director A in by	Certification:	4 Homicide	building, etc.	(Specify)				City or 10	wn, Stete)		
	Hospi 4 hou Funer tely fill	edical	29e. Certifier (Check only one) 1 Certifying Physic 2 Medical Examin	cian: To the best of er: On the basis of and manner stat	examination	ige, death occur and/or investiga	red at the t	ime, date and place, opinion, deeth occur	, and due to the rred at the time,	cause(s) end me date end place, a	nner es s ind due to	tated. the cause(s)
	within 2 To the comple	2	29b. Signature and title of certifier				29c. Licer	se number		29d. Date signed		Day, Year)
			1.5 alles				D.	30469		Hugher	30	You
			30. Name and eddress of person who cor	poleted cause of de	eth (Item 23	a) (Type, Print)	n	19,601	1-c-H	h.	40	21042
		6	1.8. VELLANKI, 70	55, CHEV	Koles	PRINE	14	100; 6	W Coll (	. /	130.	2172
	State	7	31. Dete filed (Month, Day, Year) ALIG 3 0 20	32. Registra	r's Signature	4	1					

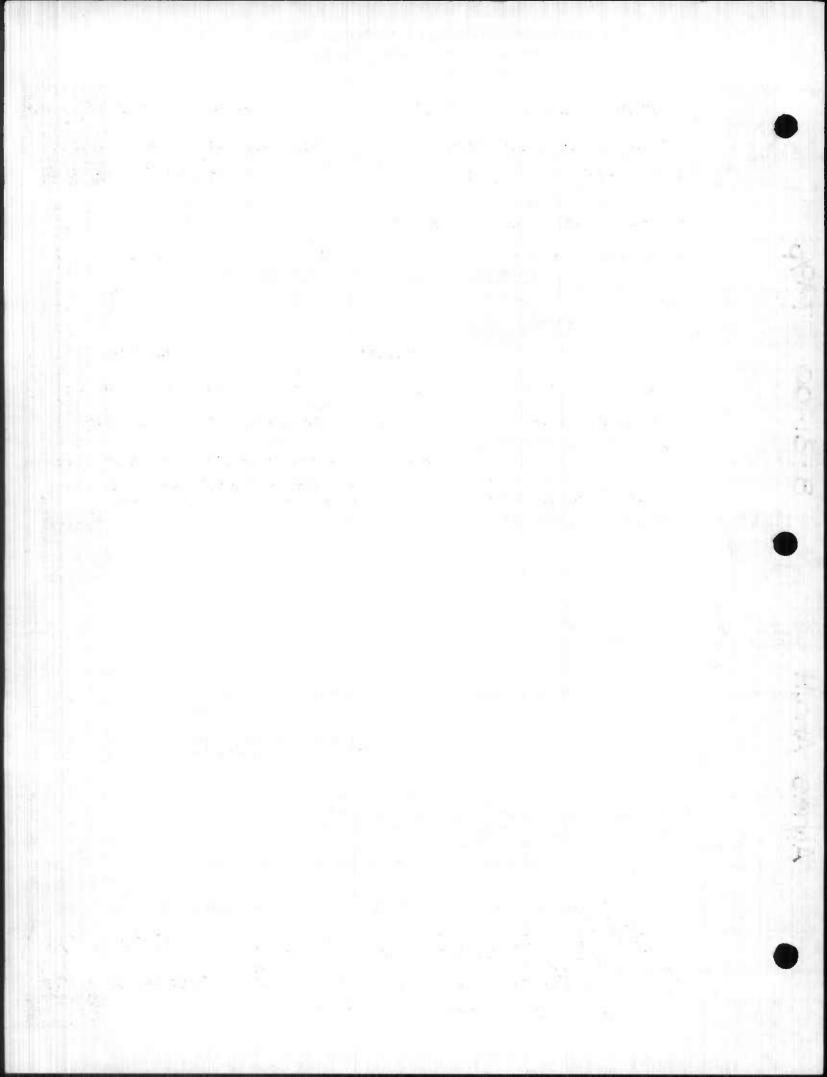
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State of Maryland / Department of Health and Mental Hygiene

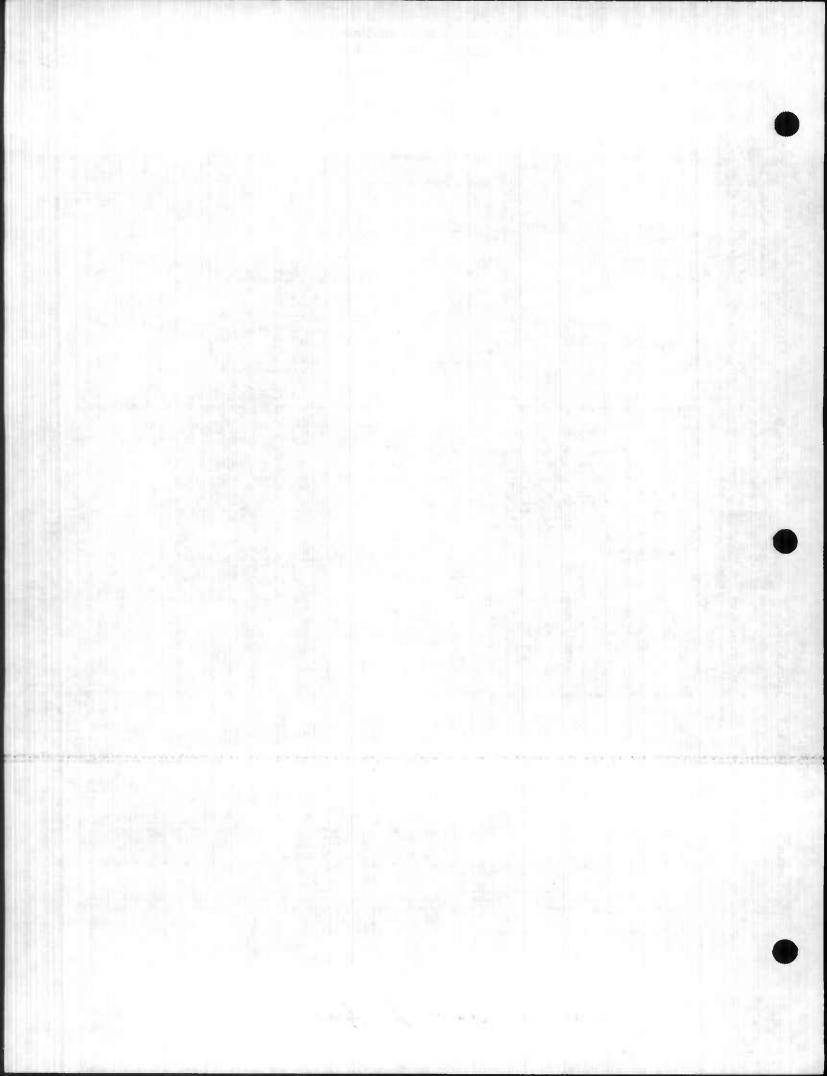
29258 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 31,2000 **Physician** Month AGNES MYRTLE AHALT August 7:20 P.M /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Williamsport Washi ff Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Day, Year) 9. E December 18,1904 Homewood at Williamsport Washington If Under 1 Yeer 9. Birthplace (State or Foreign Country) )4 Maryland 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2♥F Deys Yrs. 219-66-1202 95 Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g, Citizen of Whet Country? 16505 Virginia Avenue 21795 U.S.A. Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bieck, White, etc. 1 Never Merried 2 Merried Specify: White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) 1 and 2 should be Health end Mental Uranza Mannie Hess Myrtle Anna Gonder 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Department of Health e important: If Item 27 is any injury or other tra Wilda K. Shafer 5595 Sedwick Court, Frederick, Maryland 21702 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 09-05-2000 Hagerstown, Maryland <sup>22. Name end Address of Facility</sup> Andrew K. Coffman Funeral Home, Inc. 21. Signeture of Funerel Service Licensee noel brady 40 East Antietam Street, Hagerstown, Md. 21740 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Qnset and Deeth **Physician** /Medical Immediate Cause (Fine) disease or condition resulting in deeth) **Examiner** Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest pue physician Physician/Medical the #45 but Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy performed? this certificate has al director, page 2 2 NO 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifica Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA of 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Division 5 Pending Investigation 1 Neturel 1 Yes 2 Accident 3 Sulcide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, Stete) Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital
within 24 hours a
To the Funeral C 1 Contiting Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my ocities death. Medical 29a, Certifier dical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner stated. 29b. Signatu NED LA 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State Registrar



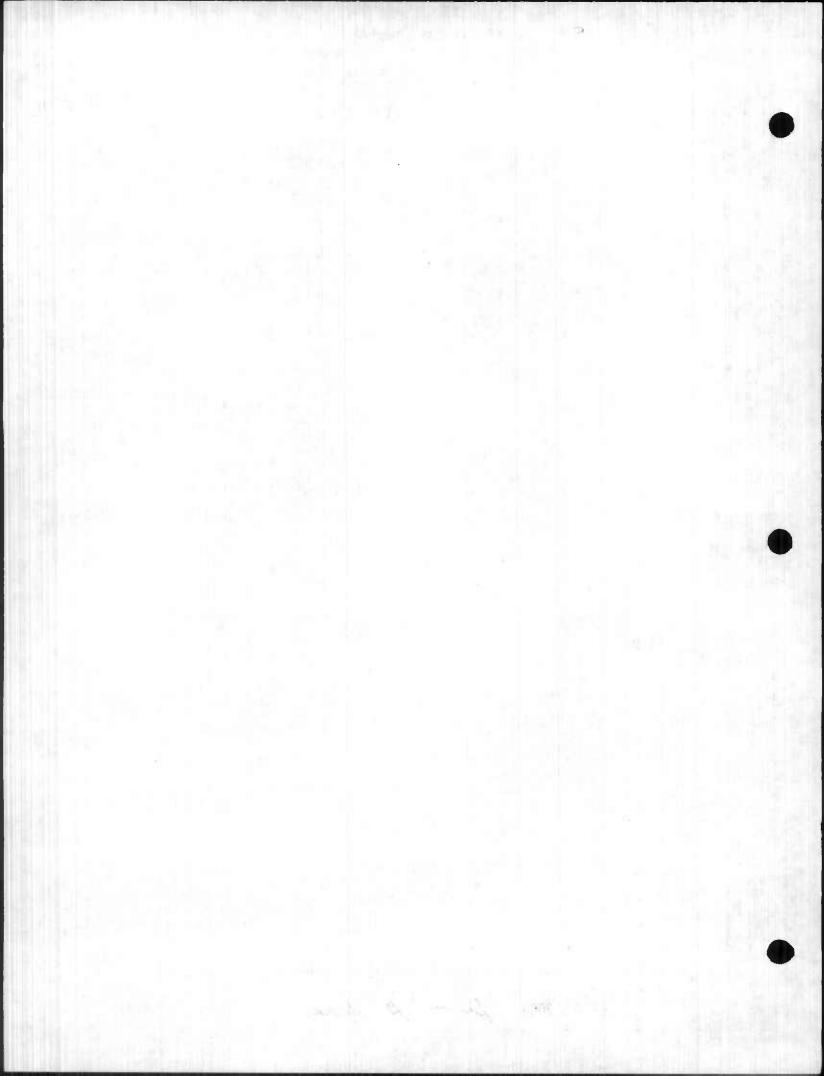
State of Maryland / Department of Health and Mental Hygiene 00 29259

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	Physician	Charlotte Genev	ieve Baker					Septemb	per 1 2	000	2pm
	/Medical Examiner	4a Facility Nama (If not institution, give	e street and number)				4b. City, Town, o	r Location of Deetl		of Deeth	U
		919 Chestnut St	reet				Hagerst	own	Washi	neto	n
	Funeral	5. Social Security Number 6. S	ax 7. Age (In yr.	s. last birthday	y) If Und	ar 1 Yaer Days	If Under 24 Hr	s. 8. Date of Bir	h		lace (State or Foreign try)
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	or 28s-1 s be notified Director	Maryland Washing	g con	Hagers		ip Code			10g. Citizen of V	Vhat Coun	try?
	The state of	919 Chestnut Stre			2	1740			U.S.A.		
	ther death with the Maryla r thems 23a or 28a-f shot siner must be notified at Furneral Director	11. Meritel Stetua	12. Wes Decedent Ever in	U.S. 13	. Was Dec	edant of I	Hispanic Origin?	Specify Yes or No		e - Americ	an Indien,
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Maryland	Mental Mental Rice even dice even di	William E. Irwin					Paulin	e Culler	S		
ary	of Bull	19e. Informant's Name/Ralationship (	Type, Print)	19b. Ma	iling Addra	ss (Stree	t and Number or I	Pural Route Numb	er, City or Town,	State, Zip	Code)
S	and 2 path as	Tamara Hoffman -	Daughter	1350	05 C1	oppe	r Road	Hagersto	wn. Md.	2174	2
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Ba	Deg many and and and	Sann	New	11	P. P.			Minnich d. Hage			land
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	Physician										Onset and Death
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н	Examiner	resulting in death)	a	(or as a cons				Fail	-		
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	certificate be executed refing physician and use as the burial-transit	Sequantially list conditions.	Due to	(or as a cons	equance of	):					
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Box	eath certific ettending pl for usa as i		d								
	the etter thed for u	Pert II. Other eignificant conditions of	ontributing to death but not re	sulting in tha	undarlying	causa gi	ivan in Part I.	23b. Dld	tobacco uae co	ntribute to	the cause of death?
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of Vital	Physician: The this certificate and director, page TO Be Co	25. Wes case refarred to medical examiner?						eath (Check only	one)		
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Division	5 2 5 C	3 Suicide 6 Could not be determined	28e. Plece of Injury - At building, etc. (Spec	home, farm, s	straat, facto	ory, office		28f. Location ( City or To	Street and Numb wn, State)	er or Rura	I Route Number,
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	To the Hospital o within 24 hours at To the Funeral Di compietaly filled is Medical Cet		yeiclan: To the best of my kr hiner: On the basis of examinand mennar stated.								
	within 2 To the comple	29b. Signatura and titla of children	2.0		2	9c. Lican	se number		29d. Date signe	d (Month,	Day, Year)
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		30. Nema and eddrass of parson who				AU					
		Howard N. Weeks, 31. Date filed (Month, Day, Year)	MD 580 Nort		lve.	Hagei	rstown,	MD 21742			
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State of Maryland / Department of Health and Mental Hygiene 00 29260

			Certificate of E	Death	Reg. No.	
Physician	1. Decedent's Name (First, Middle, Last)	the Table		2. Date	of Death	3. Time of Death
Physician/Medical	RONALD GI	LBERT BC	DWERS	0	TEMPLE Y 1	1000 11:50 An
Examiner	4a Facility Name (If not institution, give str			o. City, Town, or Location o		
	Washington Co			Hagerstown		hington
Funeral Director	5. Social Security Number 6. Sax 011-28-4872	7. Aga (In yrs. last	birthday) If Under 1 Yaar Yrs. Months Days	Hours Min. 8. Date (Mor	of Birth nth, Day, Year) Ist 20,1937	9. Birthplace (State or Fore Country) Massachuset
8 w	10a. State 10b. County	10c. City, T	own or Location			10d. Inside City Lim
iffed rot	Maryland Washin	gton Ha	agerstown			t□Yes 2□X
or 28a-f. De notifie Directo	10e. Street and Number		10f. Zip Code		10g. Citizen of W	hat Country?
23a 23a 23a 23a	11008 Palmwood	Circle	21742		U.S.A	
st, or items Examiner.m by Funer	11. Maritat Status 12  1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Evar in U,S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Yaar or Datas: 1956-1	1 Yes 2 VNo	spanic Origin? (Specify Yes n, Mexican, Puerto Rican, e Specify:	s or No- tc.) 14. Race Bleck Specify:	- Amarican Indian, K, White, etc. White
feel best	15. Decedent's Educat	tion 1	6a. Decedent's Usual Occupa	tion	16b. Kind of Bu	siness/Industry
> W W	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done do life. DO NOT use retired)	uring most of working	Massachu	setts Depart
Ner than 14. the Ma Compl			robation Of		of Corre	
Be ver	17. Fathar's Nama (First, Middla, Last)			18. Mother's Name (First,	Middle, Maiden Sumami	9)
Mente with To	Isadore		wers	Rose	Lillian	
le m	19a. Informant's Name/Relationship (Type		9b. Mailing Address (Street a			
The 27	Mary Lou Bower		11008 Palmwood	-		ryland 21742 City or Town, State
0 m 0	20a. Method of Disposition  1 ☐ Buriat 2 ☐ Cremation 3 ☐ Ren	noval from State ceme	of Disposition (Name of atery, crematory or other place			
tant jury	4 □ Donation 5 □ Other (Specify)	Shar	ron Memorial P		UUU Sharon,	Massachuset
ny in	21. Signature of Funeral Service Licensee	der	Andrew K. C	- FF F	al Home. In	C.
0200	A. neel fru	ay	40 East Ant	ietam Street	, Hagerstow	n. Md. 21740
	23a. Part1. Enter the diseasa, or complica shock, or heart failure. List only one	tions that caused the death. It cause on each line.	o not enter the mode of dying	, such as cardiac or respira	atory arrest,	Approximate Intervat Between Onset and Death
nysician		Didadam	2 502			Oriset and Death
Medical kaminer	tmmediate Cause (Final disease or condition resulting in death) a	PVINONT	724 115120	1211		YEARS
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£ 5	resulting in death) Last	Dua to (or as	a consequance of):	/		
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of for	Part II. Other significant conditions contril	buting to death but not resulting	a in the underlying cause aive	n in Part 1 23	h Did tobacco usa con	tribute to the cause of de
ed by the detached	Part II. Other significant conditions control	10 COLOR OF COLOR	PII TIC	Till Pail ().	1 Yes 2 No	3 Probably 4 □ Unk
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s been s 2 should pleted				248	a. Was an autopsy performed?	24b. Were autopsy findin available prior to complation of cause of death?
page page					1 ☐ Yes 2/☐ No	1 ☐ Yes 2 ☐ No
certificats rector, pag Be Co	25. Was case referred to medical			26. Place of Death (Check	k only one)	
200	examiner? 1 Yes 2 No Hos	spital: 1 Inpetient 2 ER	Outpetient 3 DOA Othe	f: 4 Nursing Home 5	Residenca 6 Othe	er (Specify)
	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28	b. Time of 28c. Injury Work	at 28d. De	scribe how injury occurr	ed
	2 Accident invastigation			′es 2□No		
offer deat Director: I in by the entifical	3 Suicide 6 Could not be determined	28e. Place of Injury - At homa building, etc. (Specify)	, farm, straat, factory, office		ation (Street and Number or Town, State)	er or Rural Routa Number,
al Directif		3				
within 24 hours To the Funeral completely filled Medical Ce		lan: To the best of my knowled r: On the basis of examination				
within 24 hours effer of To the Funeral Direct completely filled in by Medical Certiff	one)	and manner stated.				
To the most	29b. Signature and title of certifier	-111	29c. License		29d. Date signed	(Month, Day, Year)
	LIMIGHI	1100576	1 1/27	2045	911	00.
	30. Name and address of person who comp	oleted cause of death (Item, 23	a) (Type, Rrint)	1 140051	( ) ( ) ( )	10 2121
	1110 MEDIL	HI CAMPO	17 (7) - 120	D. MARKEY	STOWN	11) (1/43
State	31. Date filed (Month Pay Year) 5 200	32. Registrar's Signature	& Span	61		



State of Maryland / Department of Health and I	Mental Hygiene	0.0	20001
Certificate of Death	Reg. No.	00	29261
	2. Date of Death	Maria	3. Time of Death

			1. Decedent's Na
	Physicia /Medic		Beat
	Examin		4a Facility Name
			Washin
	Funeral		5. Social Security
	Director		213-38-7
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1. Decedent's Name (First, Middle, La	st)							2. Date of De		Year	3. Tima of Death
Beatrice Mar	y Beni	sek						August	Day 31	2001	1150
4a Facility Name (If not institution, giv	e street and nu	mber)	THE			4b. City, To	wn, or L	ocation of Deat	h 4c. County	of Death	
Washington Coun	ty Hose	ital			10.0	Hage	rsto	wn		Wash	ington
5. Social Security Number 6. S	өх	7. Age (In yrs.	last birthday)	If Und	er 1 Year Days	If Under			rth	9. Birth	place (State or Foreign intry)
213-38-7667	□ M 2√F	84	4 Yrs.	MOTITAL	Days	Tiouis	IVINI.	8. Date of Bid (Month, Da Jan . 30	7,1916		choslovakia
Usual Residence of Decedent		140.0									
10a. Stata 10b. County		10c. Ci	ity, Town or Lo								t Od. Inside City Limits
Maryland Washing	ton		Wi	Illia		ort					
10e. Street and Number				10f. Z	ip Code				10g. Citizen of	What Cou	intry?
11237 Kemps Mil			٠			1795				USA	
11. Manial Status	12. Was Dec Armed Fo 1 Yas	edent Ever in U prces?	J,S. 13.	Was Dec	edent of ecify Cul	Hispanic Or pan, Maxica	igin? (Sp n, Puarto	pecify Yas or No Rican, etc.)	0- 14. Rad Bla	ca - Amar ck, Whita	ican Indian, , etc.
1 Nevar Married 2 Married	If Yes, Gi	Ve		1 Yes	2X No	Specify.			Specif	y:	
3 X Widowed 4 □ Divorced	Yaar or D	atas:									ite
15. Decedent's Ed (Specify only highest gre	lucation de completed)		16a. Dece (Give	dent's Us	vork done	pation a du <i>n</i> ing mos ad)	st of work	king	16b. Kind of B	usiness/li	ndustry
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12 17. Fathar's Nama (First, Middle, Last)				JOOKN	eehe		or's Nam	o /Firet Middle	Maiden Sumen		racturer
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Joseph			Hoza		40.			ncisca			ava
t9a, fnformant's Name/Relationship (	Type, Print)								per, City or Town,		
John Benisek/Son		004	1123 Place of Dispo			Mill	Rd.		sport, M		
20a. Method of Disposition  1 Burial 2 Cramation 3	Removal from		cametery, cre	matory or	other pl	эсе)		Date	20c. Location	- City or 1	own, Stata
4 □ Donation 5 □ Other (Specific			ithsbur	g Cr	emat	ory	9	-1-00	Smithsb	urg,	Maryland
23a Part. Entry le disaase, or com anoch or mort failure. List only Immediate Cause (Final disease or condition	plications that cone cause on a	caused the dea	th. Do not en	ter the mo	ode of dy	ing, such as	cardiac	or raspiratory a	arrest,	1 1	Approximata Interval Between Onset and Death
resulting in death)	a	Due to (	or as a conse	quence of	1):						Carl III
	b 0	the	sde	1000	2					i	Jean
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	Q					70.5			7.1. 79		
Part II. Other significant conditions of	ontributing to d	eath bul not res	sulting in the u	ınderiying	cause g	iven in Part	l.	23b. Did	l tobacco una co	ntributa	to the cause of death?
Pala.	. I and							10	Yea 20 No	3 🗆 Pr	obably 4 Unknown
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examiner? 1 ☐ Yes 254,No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 🗆 🛭	OOA O	ther: 4 N	ursing Ho	ome 5□Res	idence 6 Oth	ner (Spec	cify)
27. Manner of Death  NONatural 5 ☐ Pending	28a. Date (Mon	of Injury th, Dey Year)	28b. Time o	of	28c. Inju	ury at ork?		28d. Describe	how injury occur	rred	
Accident investigation				М		Yes 2	No				
3 Sulcide 6 Could not be determined	288. Place	of Injury - At hing, etc. (Speci	nome, farm, st fy)	reet, facto	ory, office				(Street and Number, State)	ber or Ru	ral Route Number,
29a. Certifier 15 Certifying Ph (Check only one) 2 Medical Exam	iner: On the b										
29b. Signatura and titla of certifiar				2	9c. Licer	se number			29d. Date signa	ad (Monti	, Day, Year)

Physician /Medical Examiner

To the Hospital or Attending Physician: The lew requires that the death certificate be assected within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burist-trans.

Division of Vital Records, P.O. Box 68760,

Beatrice Benisek

Baltimore, N

	0		24a. Was an autopsy performed?	24b. Were autopsy findin available prior to completion of cause of death?
			1□ Yes 2⊠ No	1 ☐ Yes 2 ☐ No
25. Was case referred to medical		26. Place of Deatl	h (Check only one)	
examiner? 1 ☐ Yes 25,No	Hospitat: 1 Inpatient 2 ☐ ER/Outpatient	3□ DOA Other: 4□ Nursing Ho	me 5 Residence 6 Oth	ner (Specify)
27. Manner of Death Natural 5 Pending investigation		28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injury occur	rred
all Sulvide 6 Could not b				

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27. Manner of Death Natural Accident	5 Pending investigation	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury at Work?	2 🗆 No	28d. Describe how injury occurred
3 ☐ Sulcide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fac fy)	tory, office		28f. Location (Street and Number or Rural Route I City or Town, State)
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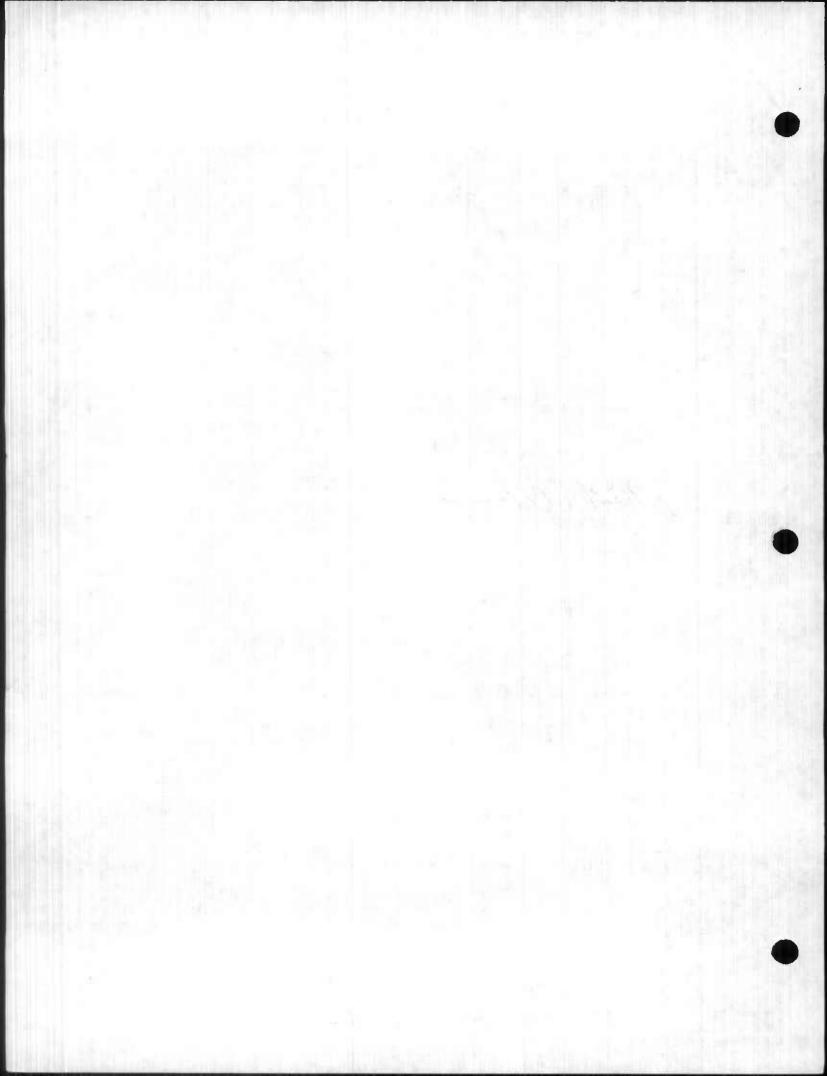
29a. Certifying Physician: To the best of my knowledge, death or (Check only one) 2 Medical Examiner: On the basis of examination and/or invest and manner stated.		
29b. Signatura and titla of certifiar	29c. License number	29d. Dale signad (Month, Day, Year)

29b. Signatura and titla of certifiar	29c. License number	29d. Dale signad (Month, Da		
► 1811 72 Dha	D0011266	Sold 1 CO		

Hagerstown 32. Registrar's Signature

State Registrar

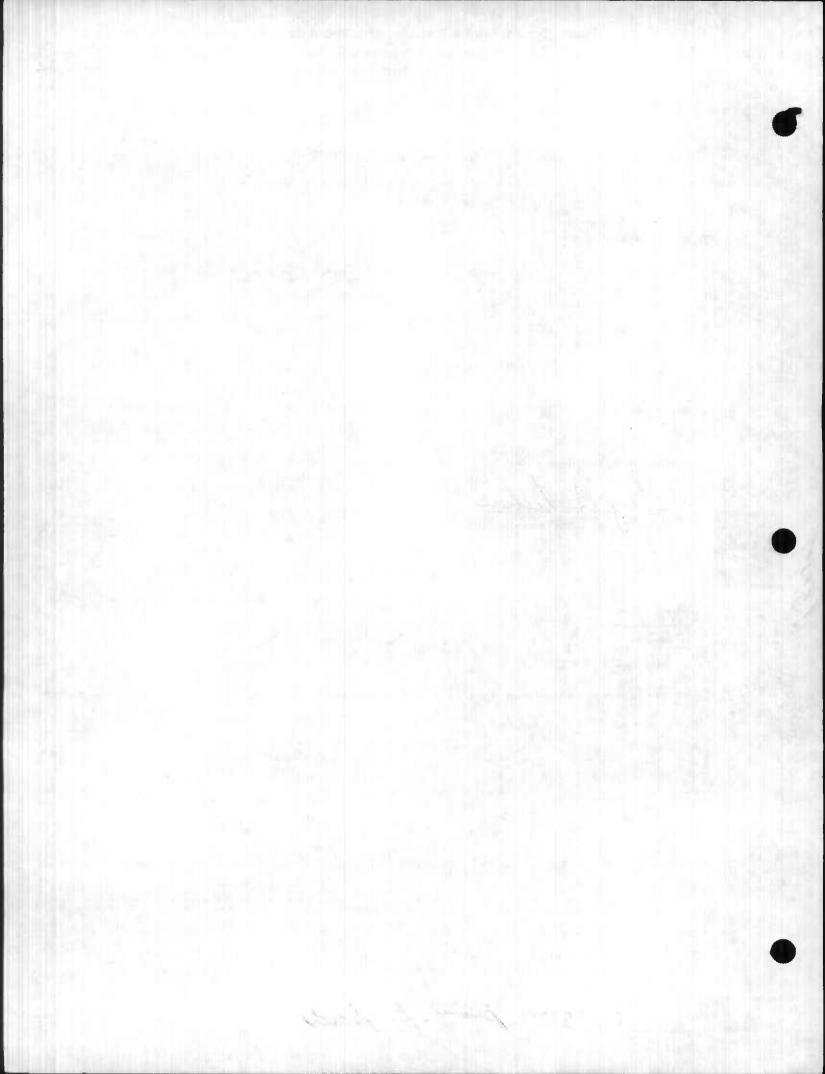
31. Data filed (Month, Day, Year) SEP 0 6 2000



State of Maryland / Department of Health and Mental Hygiene

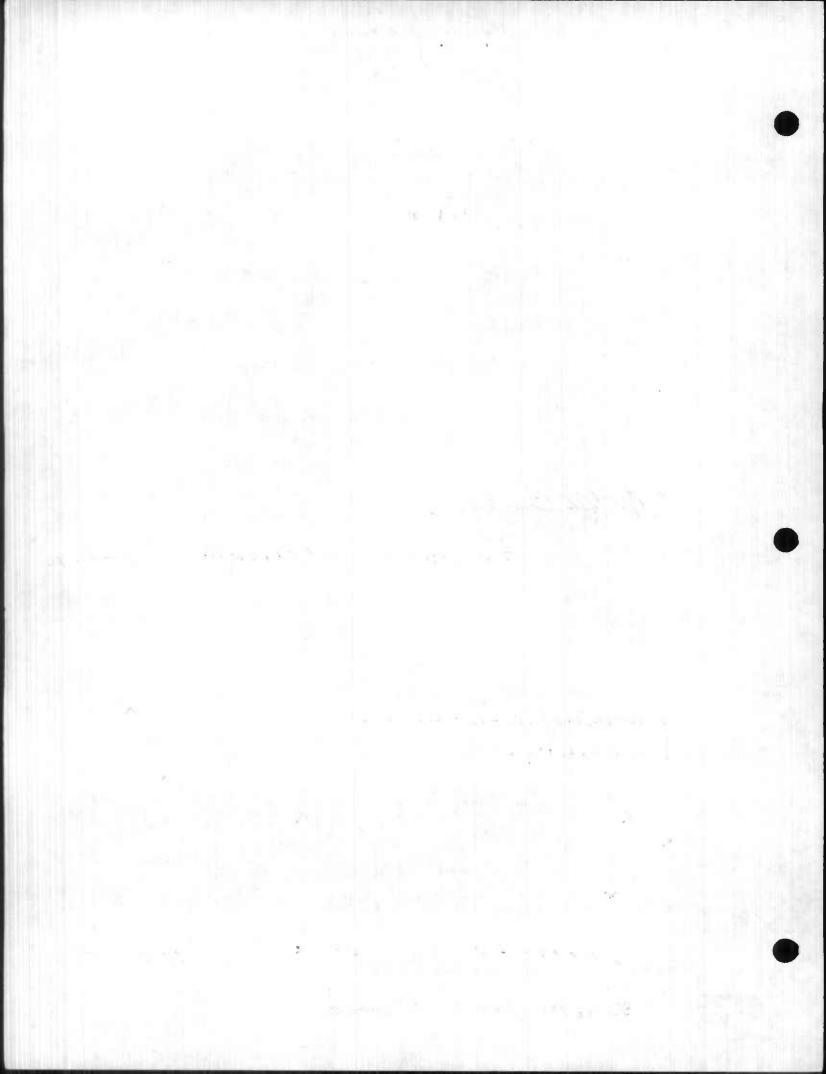
Physician		#10D PER F.H. G787 9-28-00 WR. Certificate (							2. Dete of De Month	Day	Year	3. Tima of Death					
/Medical	1	Louise Beck Bai			Augus7	27 21	000	10:25 AM									
there death with the Maryland reference 23a or 24e-f show for must be notified at forecraft Director Funeral Director	40	Facility Neme (If not institution,			cation of Deat	4c. County	of Death										
		Union Hospital	If Under 1 Ye		ton er 24 Hrs.	0.0	Ceci		10.1.								
		Social Security Number  217-36-1096  sual Residence of Decedent	6. Sex 1 □ M 20XF	1. Age (in you had billious)			rs Hours		6. Date of Bir Month Da July 29	1920	Country	ce (State or Foreign eville, MD					
	10	Da. State 10b. County									I. Inside City Limits  1 ☑ Yas 2 ☐ No						
		Maryland Cecil		Ce	ecilton				1			Λ					
	10	De. Street and Number		10f. Zip 0						10g. Citizen of What Country?							
		14 Center Stree		cedent Ever in	116 13	21913		Origin? (Sp	acify Yes or No	USA 14. Back	e - American	Indian					
by by		1 Never Married 2 Married 3 Wildowed 4 Divorced	Armed F	Forces? 2 Zano Give		Was Decedent of If Yes, specify C			Rican, etc.)	Specify Specify	k, White, atc	c.					
r. tre Medical		15. Decedent (Specify only highest Elementary/Secondary (0-12)	t grade completed	d) (1-4or 5+)	(Give	edent's Usual Occ be kind of work do DO NOT use ret	ne during m	ost of work	ing	16b. Kind of Bu		stry					
Co		10 7. Father's Name (First, Middle, L	( eat)		Homem	aker	16. Mother's Name (First, Midd		. /First Middle	Own Hom							
. 0 2		Clifton T. Beck								, waiden Sumam	.0/						
marked matic e	· -	9a. Informent's Neme/Relationsh			19h Melli	ing Address (Stra			ittle	er, City or Town,	State Zin C	code)					
27 ia r r traur		Carolyn Subolef								Marylan							
E	-	Da. Method of Disposition		20b		osition (Name of omatory or other p		DGT TO	Date	20c. Location -							
		1 Burial 2 Cremation		n State			olace)		/30/200	n Cooil	ton N	Marviland					
Important: hany injury o		1. Signature of Funeral Service L 234. Part 1. Enter the disease, or shock, or hear failure. List of	Fello	us	F 2:	2. Name and Add ellows, 26 E. Ma	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Fellows, Helfenbein & Newnords Editors 22. Name and Address of Facility Fellows, Helfenbein & Newnords 22. Main Street, Cecilto										
n and iel-transit tauju Examiner			only one cause on	each line.	atii. Do not en		aying, such i	es cardiac (	or respiratory a	irrest,	le le	Approximate Intervel Between Onset end Death					
burie-transit	di re	inmediate Cause (Final issaes or condition southing in death)  sequentially list conditions, any, leading to immediate ause. Enter Underlying ause or Injury		Due to		ulan a quence of):	ceia	len7			2	ntervel Between					
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DHMH 16 Ray 6/95



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					Cei	rtificate of	Death		Reg	. No.		
Physician /Medical		BRIDGET		IS				Se	onth pt. 2	Dey 2000	Yeer	3. Time of Death 8:45 PM
Examiner		(If not institution, git Nursing &	Rehab	ilitation			Berlin			4c. County Worce	ster	
Funeral Director	5. Social Security Number 219 30 3740  Usual Residence of Decedent  5. Sex 1 M 26 F 91					If Under 1 Yea Months Day		Min. (N	ate of Birth fonth, Day, 1 rch 3	Birth Say, Year)  9. Birthplaca (State or Foreign Country)  1. 30,1909   Ireland		
Maryland a-f show itled at	10a. State MD	10b. County Worces	ter		ean Cit						10	d. Inside City Limit:
iff with the Maryla 23a or 28a-f show ust be notified at ral Director											y?	
urs after don alf., or itsems Examiner m by Fune		rried 2 Married	Armed F	2X No		Was Decedent of If Yes, specify Cu 1 ☐ Yas 2 💢 No		gin? (Specify Y , Puerto Rican		14. Rac Blac	a - America ck, White, at White	tc.
ed within 72 ho ygiene. wer than "neturn It, the Medical. Completed		15. Decedent's E	ade completed)		16a. Deced (Give life.	dent's Usual Occi kind of work don DO NOT use retir	upation e during most red)	t of working	16	6b. Kind of Bu	usinass/Indu	stry
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Monta mrked with ev		eter Revi						y Demp				
alth and 27 is m or treum	Jeanne	Name/Relationship ( Dickson	Type, Print)			Boston					Steta, Zip ( 21811	Code)
or other		sposition Cremetion 3 [ 5 Other (Speci		Stete	cemetery, cret	nsition (Neme of metory or other pi hedral (		Da		20c. Location - City or Town, State  Baltimore, MD		
Department important: eny injury ance.	21. Signature al.F	peral Service Lice	nsee	, .		2. Name and Add urbage					Villiam St.	
osati benincate by secured of a secured of the secu	disease or condition resulting in death,  Sequentially list or if any, leading to cause. Enter Unc Cause (Disease of that initiated even resulting in death)	onditions, mmediate lerlying r injury ts	b	Due to	(or as a consector as	quance of):		ZOK				01743
of the death cert of by the attendin letached for use Physician/N	Part II. Other sign	ificant conditions	contributing to d	leath but not re	sulting In the u	nderlying cause (	given in Part I.		23b. Did tob	acco use co	ntribute to	the cause of deat
5 00	An	tenino	ty.						1 Yes 2 No 2 Probably 4			ably 4 Unkno
shou		e wil	Ly.			Ber		2	24a. Was an perform		avai	ra autopsy findings lable prior to apletion of cause aath?
yerclen: The lay s certificate has director, page 2  To Be Comp									1 🗆 Yas		10	Yes 2□ No
this certific ral director.	25. Was case rafa axaminar?	No medical	Hospital:	Inpatient 2	☐ ER/Outpatier	nt 3 DOA	ther:	of Death (Cha			er (Specify)	)
in one mospital or Attending Physicians (1904) within 24 hours after death.  To the Funesal Director: After this completely filled in by the funeral director Attending Medical Certification: To	27. Mannar of Dea 1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pending investigation 6 Could not be determined	n 28e. Plac	of Injury oth, Dey Year) e of Injury - At ling, etc. (Spec	28b. Time o injury	W	Yes 2 1	No 28f. L				Route Number,
within 24 hours at To the Funeral D completely filled I												
Within 2	one) 29b. Signature an	d title of certifier	and mar	nner stated.	Deat 18	29c. Lice	nse number		29	d. Date signe	d (Month, D	Pey, Year)
,,,	•	In	m	7		20	2060	9	1	-p4	1-20	000
° State Registrar		ress of person who lerico Art sep Day, Year) DEP 0 6 20	hes 97		lthway		erlin,	MD	21811			



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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0 (		4	7	2	0	4

2000 7;14 PM

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 3 HELEN WHEELER COOKSEY 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ST. MARY'S HOSPITAL LEONARDTOWN If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey)

ST. MARY'S 8. Dete of Birth (Month, Day, Year) Birthplaca (State or Foreign Country)

**Funeral** Director

or 28a-f show

238

Berna

8

Completed

hours after

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filed within

permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked or any injury or other traumatic eve

**Physician** /Medical

Examiner

physician is the buria

USB 88

signed by to

page 2 should

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After

death.

6

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within 24 hours a To the Funeral C completely filled Hospital

The law requires that the death certificate be executed

Box 68760.

Records, P.O.

Vital

of

Division Attending

HELEN COOKSEY

Examiner

Physician/Medical

Be Completed

Certification: To

edical

Baltimore, Maryland 21215-0020

Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location

10f. Zip Code

Months

Yrs.

LEONARDTOWN

Deys

MARYLAND 10d. Inside City Limits

Yes 2 No

MARYLAND ST. MARY'S 10e. Street and Number

218-24-3233

M00641

77

10g, Citizen of What Country?

4c. County of Death

Dir Funeral

22680 CEDAR LANE COURT APT. 1320

20650 Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Hours

U. S. A. 14. Race - American Indian, Bleck, White, etc.

1 Never Married 2 Married 3€XWidowed 4 Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes:

College (1-4or 5+)

10 M 20 F

1 Yes 2 No Specify:

Specify: WHITE 16b. Kind of Business/Industry

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager

Camp Sites

17. Father's Neme (First, Middle, Last)

12

88 GEORGE LUKE WHEELER 2

18. Mother's Name (First, Middle, Meiden Surneme) CATHERINE MILDRED HAMMETT

SEP. 17,1922

19a. Informant's Name/Relationship (Type, Print)

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code)

JOANNE GOOD / DAUGHTER

11305 DEER FARM PLACE LA PLATA, MARYLAND

20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State SEP Tate

1 Buriel 2 □ Cremetion 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)

HOLY FACE CHURCH CEMETERY 7,2000 GREAT MILLS, MD 22. Name and Address of Facility BRINSFIELD-ECHOLS FUNERAL HOME, P.A

ture of Funerel Service Licensee

30195 THREE NOTCH RD CHARLOTTE HALL, MD 23a. Perty. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Finat diseese or condition resulting in death)

Approximate tnterval Between Onset and Deeth

Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (of as a consequence ot):

23b. Dtd tobacco use contribute to the cause of death?

Part It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

1 Yee 2 No 3 Probably 4 Unknown

24a. Was an autopsy

24b. Were autopsy findings avellable prior to completion of cause ot death?

1 ☐ Yes 2 No

26. Place of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

25. Was case reterred to medical 1 ☐ Yes 2 ■ No

6 ☐ Could not be determined

28a. Date of tnjury (Month, Day Year) 5 Pending investigation

1 ☐ Inpatient 2 ■ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify)

e ot death (Item 23a) (Type, Print)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner es stated Described Examtner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29c. License number

29b. Signature an title of certifier

27. Menner of Death

1 Neturat

2 Accident

3 Suicide

4 Homicide

29d. Dete signed (Month, Day, Year)

28t. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and a

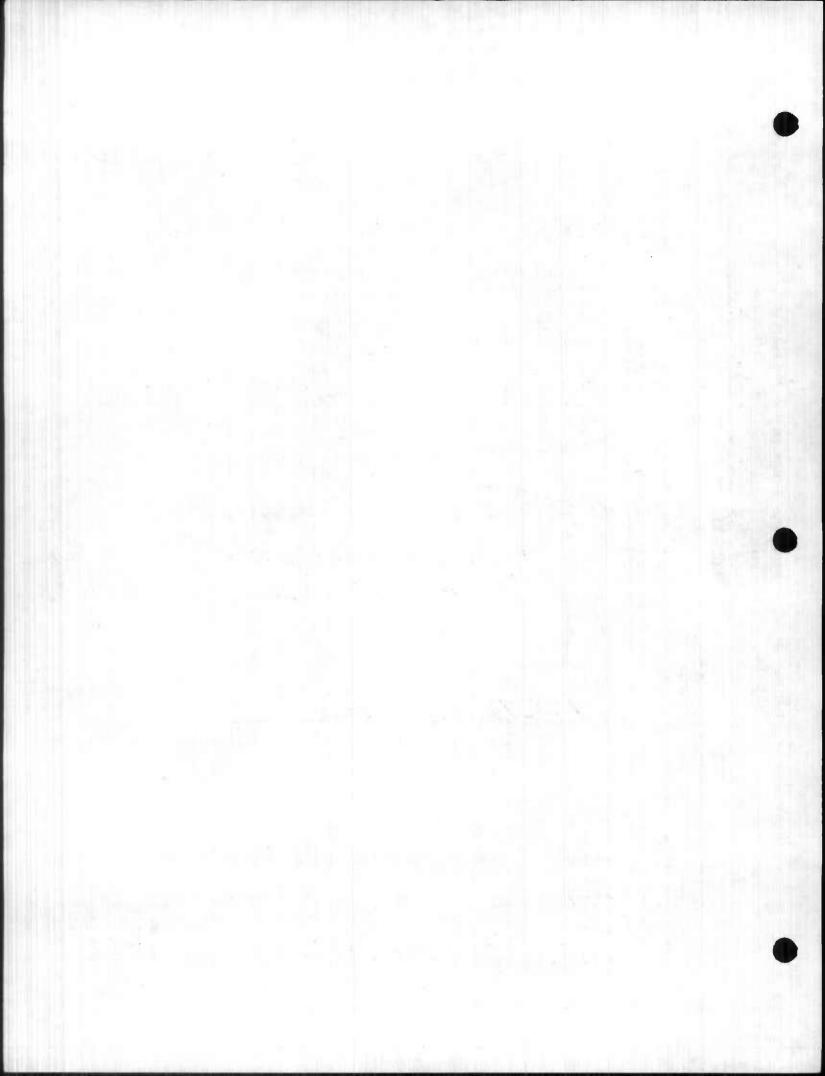
.JARBOE M.D.

PMILIP J. BEAN MEDICAL CENTER HOLLYWOOD, MD. 20636

State Registrar

2. Registrar's Signature 31. Date filed (Nonth, 6

open



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29265 AMEND FIEM: #20B PER F.H. G788 10-21-00 WR. Certificate of Death 1. Decedant's Neme (First, Middle, Last) 3. Tima of Death 2. Dete of Deeth Month
AUG. 20, 2001
- Paath 4c. County of Death **Physician** CAMPBELLSR ARCHER AMES 17=00 2000 /Medical 4e. Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FOREST HICL ROCKSPRING MO HARFOND Aga (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Sociel Sacurity Number 6. Sex Birthplece (State or Foreign Country) **Funeral** Days 10 M 20 F 87 217-14-2873 Yrs Maryland Director Usuai Rasidanca of Decedent 10e. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f show 1 Yas 20 No Director Forest Hill MD. Harford 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1801 Rock Spring Road 21050 U.S.A. 12. Wes Decedent Ever in U,S.
Armed Forces?
1 Yes 2 No
If Yas, Giva Wes Dacedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puarto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Navar Married 2 Married 1 Yes 2 No Specify: by Specify: Caucasian 3 AWidowad 4 □ Divorced Yaar or Detes: Completed the Medical 18a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Baltimore nd Mental Hygiene. marked other than Elemantary/Secondary (0-12) College (1-4or 5+) 11 Gas & Electric Lineman 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Be permit. Pages 1 and 2 should be to Department of Health and Mental Important: If Item 27 is marked of any Injury or other traumatic ever Robert Emmett Campbell Clara Watters 19a. Intormant's Name/Raiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) James A. Campbell Jr./Son 1000 Amberly Court Bel Air, Md. 21014 20a. Method ot Disposition 20b. Plece of Disposition (Nama of cemetery, cramatory or other place) 20c. Location - City or Town, Steta Date Burial 2 Cramation 3 Ramoval from Steta 8-24-00 4 ☐ Donation 5 ☐ Othar (Specify) Air Mem. Gardens Bel Air, Maryland 21. Signetura of Funerei Servine Lice 22. Nama end Address of Fecility E.G. Kurtz & Son Funeral Home, P.A. IL Jarrettsville, Maryland Mac 23a. Part1. Enter the disease, or complications that caused includes the death. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each limit Lon Approximata interval Between Onset and Death Physician Immediate Causa (Final diseasa or condition rasulting in daath) ASLUD Examiner Dua to (or as a consequence of): Examiner siclan and burial-transit Sequantielly list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or injury that initiated avants rasulting in death) Lest Dua to (or as a consaquance ot): physician is the burial Physician/Medical Dua to (or es e consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ate has been signed by page 2 should be detac 1 Yee 2 No 3 Probably 4 Unknown HYPERTENSION þ 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 2 No this certificate 1 Yas 25 No Be 25. Was casa retarred to medical 26. Placa of Death (Check only one) axaminari Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 10 1 Yes 2 No 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima ot 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending investigation 1 W Naturai 1 ☐ Yas 2 ☐ No 2 Accident

Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica stely filled in by the funeral director.

72 hours after

Baltimore, Maryland 21215-0020

FCXT

To the Hospital within 24 hours a To the Funeral Completely filled

Certification:

State

29b. Signature and titla of certitian

6 Could not be datarmined

28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

29d. Dete signed (Month, Day, Year) AUG 20

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

30, Name and address of person who complated cause of death (Item 23a) (Type, Print)

NABHU 728BELANL BEZATI MO 21014 an

31. Data tilad (Month, Day, Year)

3 Suicida

29e. Certifier

Medical

4 ☐ Homicide

(Check only one)

32. Registrar's Signatura AUG 2 3 2000

1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stetad.

29c. Licensa number

Registrar

#### Please Type or Print in Black Indelibie ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death amend item 23a per phys. G787 9/14/00 yf 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Richard O. Carville, Sr. 24, 2000 4:15 PM 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Oak Crest Village Care Center Parkville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 1 M 2□ F 375-10-4141 86 Yrs. Arkansas June 24. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. toslde City Limits Maryland Baltimore 1 ☐ Yes 2 No Parkvillo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 Walther Blvd., Apt. 1210 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 □ X'es 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritet Status 1 Never Married 2 Married 1 Yes 2 No Specify: White. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Chemical Mechanical Engineer 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Arthur F. Carvillo Josephine Christian 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 8810 Walther Blvd., Thelma G. Carville Apt. 1210, Parkville, MD 21234 (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete All Saints Cemetery 7/28/00 Wilmington, Delaware 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on add line. Approximata interval Between Onset and Deeth 2-3yrs END STATE RENAL DISEASE Immediate Cause (Final disease or condition resulting In death) WIE KENAL weaks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lest Due to (or as a consequence of) Due to (or es e consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown 24b. Were autopsy findings 24a. Was an autopsy CONGESTIVE HEART PAILURE available prior to completion of cause of death? ATRIAL ABRILLATION 1 Yas 2 No 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1□ Yes 2□ Yo 4 Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 Yes 2 No

68760, P.O. of Vital Records. Division Attending death. after deat Director:

Physician

/Medical

Examiner

Physician/Medical Examine

Be Completed by

Certification: To

edical

3 Suicide

4 Homicide

**Physician** 

/Medical

Examiner

Director

Funeral

**Funeral** 

Director

HYPERTENSION 25. Was case referred to medical examiner?

6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Beltmare MD 21234

29a. Certifier 29b. Signeture end title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

within 24 hours a To the Funeral D completely filled Hospital

To the

State Registrar 31. Date filed (Month, Day, Year) JUL 27 2000

pulknermo

8800 Walther 32, Registrar's Signature

Address of the second Later Light of Your Control of SALLEY PART SAIDS DES Introduct LAP on and the state of t 10 mm 1 5 JUL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended Item 2 per Phy. State of Maryland / Department of Health and Mental Hygiene 08/31/2000, Carroll County, wjl Certificate of Death Reg. No. August 27 Day 2000 ear 1. Decedent's Nama (First, Middle, Last) **Physician** Charles Joseph DeLorenzi 3:51 /Medical 4a Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll 3 Sycamore St. Westminster Birthplaca (State or Foreign Country) 8. Data of Birth (Month, Day, Year) If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Months Hours 1**∑** M 2□ F 76 217-20-0656 Yrs Director Oct. 16. 1923 Maryland Usuat Rasidenca of Dacedant the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits raf', or items 23s or 28s-f show Examiner must be notified at Mas 2□No Director Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 USA Sycamore St. Funeral 12. Wes Decedant Ever in U,S. Armed Forcas? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 72 hours after 1 Tyas 2 No 1943 — If Yas, Giva Year or Detes: 1945 1 Nevar Married 2 Merried natural, or altimore. Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry filed within Curtis Bay Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4+ Accountant Towing Co. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If flem 27 Is marked oth any injury or other traumatic avent pates. 17. Fether's Nama (First, Middle, Last) 18. Mothar's Neme (First, Middle, Meiden Surname) Be Achille DeLorenzi Rose DeRosa 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 335 N. Springdale Rd. Westminster, MD 21157 Maria Keeney - Sister 20b. Place of Disposition (Neme of 20c. Location - City or Town, State 20a. Mathod of Disposition Data cemetary, cremetory or other place) Cathedral Cemetery 30, 2000 Baltimore City 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signature of Funaral Service Dicensee 22. Nama and Addrass of Facility Pritts Funeral Home and Chapel 412 Washington Rd. Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaase or condition rasulting in death) Examiner Examiner Sequentially list conditions, if any, lasding to immadiata causa. Entar Undarlying Cause (Diseasa or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): and Rcers Box 68760 8 Physician/Medical and the Dua to (or as a con P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? à 1 Yss 2 No 3 Probably 4 Unknown been signed the should be det Division of Vital Records. py 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yas 2 No 1□ Yas 2□ No 25. Was casa refarred to medical examinar? Be 26. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of Injury (Month, Day Year) 27. Menner of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Attending 1 Natural 5 Pending n 24 hours after death.

The Funeral Director: After Silver of the funeral by the 1 ☐ Yas 2 ☐ No investigetion 2 Accidant 6 ☐ Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 8 Hospital 29a. Certifier Medicai Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and mannar stated. (Check only one) 29c. License number 29d. Data signad (Month, Day, Year) 29b. Signetura end titla of certifia 30. Nama and address of person who complated causa of death (Item 23a) (Type, Print) Sults 203 Towson, MD 21204 31. Dete filed (Month, Day, Year) 32. Registrar's Signatura State

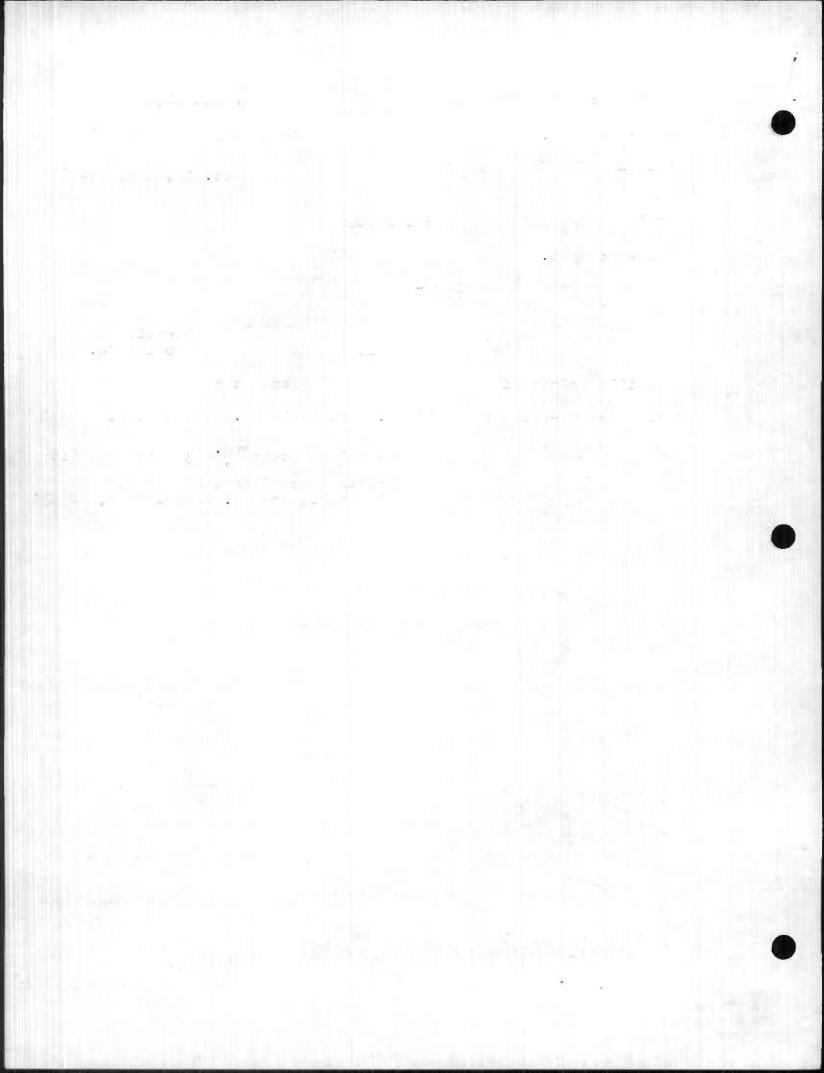
DHMH 16 Rev 6/95

Registrar

AUG 3 1

2000

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dele of Death **Physician** AUGUST 30, 2000 9:30 AM Charlotte Elizabeth EBERLY /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death Examiner RAVENWOOD LUTHERAN VILLAGE HAGERSTOWN WASHINGTON If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 1 ■ M 2 🛛 F 93 Yrs. May 30 1907 Director 217-16-2090 Pennsylvania Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Director Hagerstown Washington Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rems 23s or 17622 York Road 21740 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Yeer or Deles: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11 Marital Status Black, While, etc. 1 ☐ Never Married 2 ☐ Married 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 DWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Her own home Homemaker Unknown Unknown permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If Item 27 is marked other any Injury or other transment other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) 88 Lo Olive Rife Hiram H. Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ratationship (Type, Print) Baltimore, Maryland 21214 3410 White Avenue Anthony Mignini 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removel from Stete 9/2/00 Greencastle, Pennsylvani 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Hill Cemetery 21. Signeture of Europeal Service License 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** /Medical Immediata Causa (Finat disease or condition rasulting in daath) ACUTE CARDIOPULMONARY ARREST INSTANT Examiner Dua to (or as a consequence of): MANY Examiner HYPERTENSIVE CARDIOVASCULAR DISEASE YEARS iclan and bunal-trans Sequantially list conditions, if any, laading to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Due to (or es e consequence of): 88 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ANEMIA, DEHYDRATION, INANITION, MALNUTRITION, þ Records, 58 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed DEMENTIA DUE TO PREVIOUS STROKE page 2 2 0 No 1 ☐ Yes 2 ☐ No of Vital Be 25. Was casa referred to medical examiner? 26. Place of Death (Check only ona) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner-of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Panding Investigation or Attending 1 Naturat 1 Yas 2 No death. 2 Accident after death Director: 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At homa, ferm, street, factory, office building, etc. (Specify) 4 Homicida 24 hours a Hospital 29a. Certifier Telegraphic Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and manner as stated. edical tely (Check only one) 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 島 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D07857 AUGUST 31, 2000 dien Her

Registrar

Elizabeth EBERLY

Charlotte

State

1190 MT. AETNA RD., HAGERSTOWN, MD.,

21740

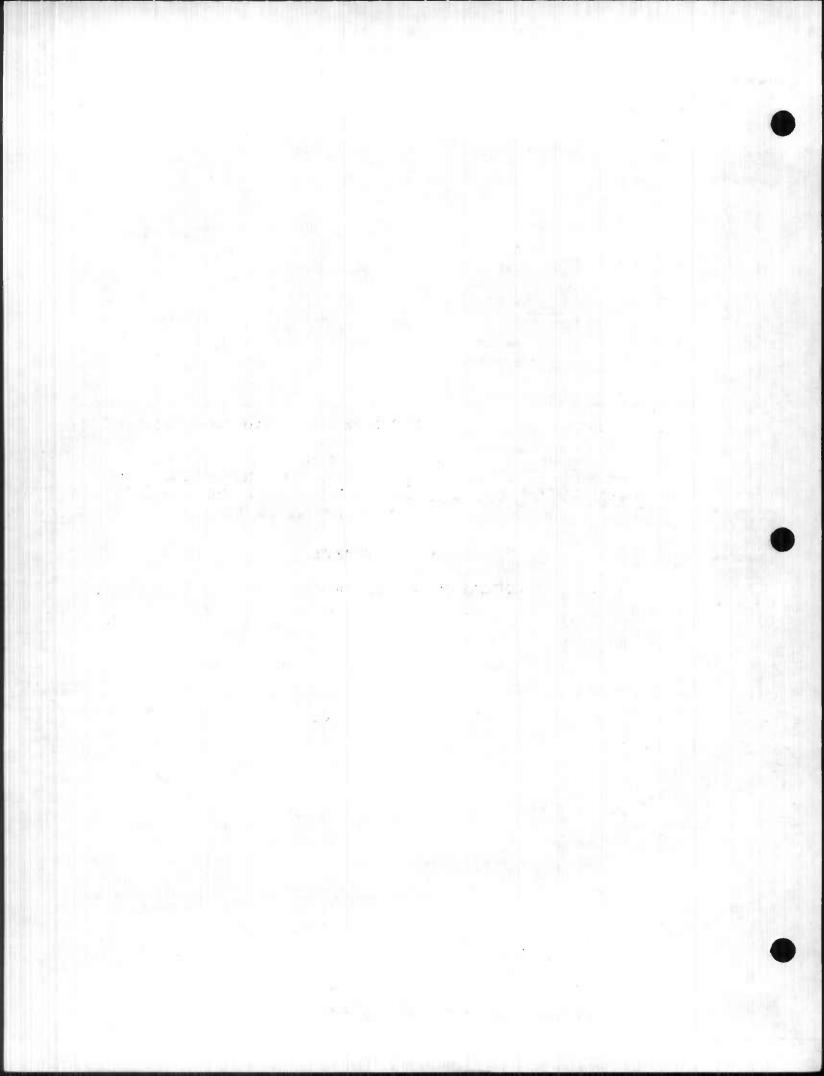
30. Nama and address of parson who complated cause of death (Item 23a) (Type, Print)

32. Registrar's Signatura

DR. EDSON MOODY MD.,

SEP 0 1 2000

31. Data filed (Month, Day, Year)



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 6 per fh G791 1/4/01 yf Certificate of Death 1. Decedent's Neme (First, Middle, Last, 2. Date of Deeth 3. Time of Death **Physician** DONNA 10:00 AM 4b. City, Town, or Location of Deeth 2000 /Medical 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner UNIVERSITY BALTIMORE Baltimore City OF MARYLANT If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign Funeral 10 M 28 F Months Deys Hours Washington, D.C. 74-682 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahow the Medical Exampler must be notified at the Marylar Montgomery XX Yes 2 No Director Riverdale Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America 5310 67th Avenue 20737 Funeral filed within 72 hours after death Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Merried 2 ☐ Merried Specify: Black Baltlmore, Maryland 21215-0020 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Administrator Assitant other 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be file Department of Heelth and Mental by Important: if Itam 27 is marked oth any Injury or other traumatic avent page. 17. Father's Neme (First, Middle, Last) Gwendolyn Johnson James Jordan 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5310 67th Avenue Riverdale, Maryland 20737 Charlie Easley 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 8-29-00 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Forest Hills Cemetery 21. Signature of Fundigues State Company 22. Name and Address of Facility Robert O. Freeman Funeral Services Fireeman Washington, D.C. 20002 Glenda M. 1353 H Street N.E. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of) Examine Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No Probably 4 Unknown by 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Wes an autopsy performed? Completed Artery Disease 1 ☐ Yes No 1 Yes

The law requires that the death Division of Vital Records, P.O. or Attending Physician: Be 1º Certification: After death. Director: / 2

25. Was case referred to medical examiner? 3 No 1 Yes

5 Pending investigation

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Plece of Deeth (Check only one)

6 Could not be 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

29a. Certifier

27. Manner of Death

Natural 2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and attle of cartifier

29c. License number

1 Yes 2 No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

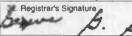
UNIVERSITY OF MARYLAND 22 S. GREENE ST BALTIMORE MOZIZOI ESLIE BELLOSO

State Registrar

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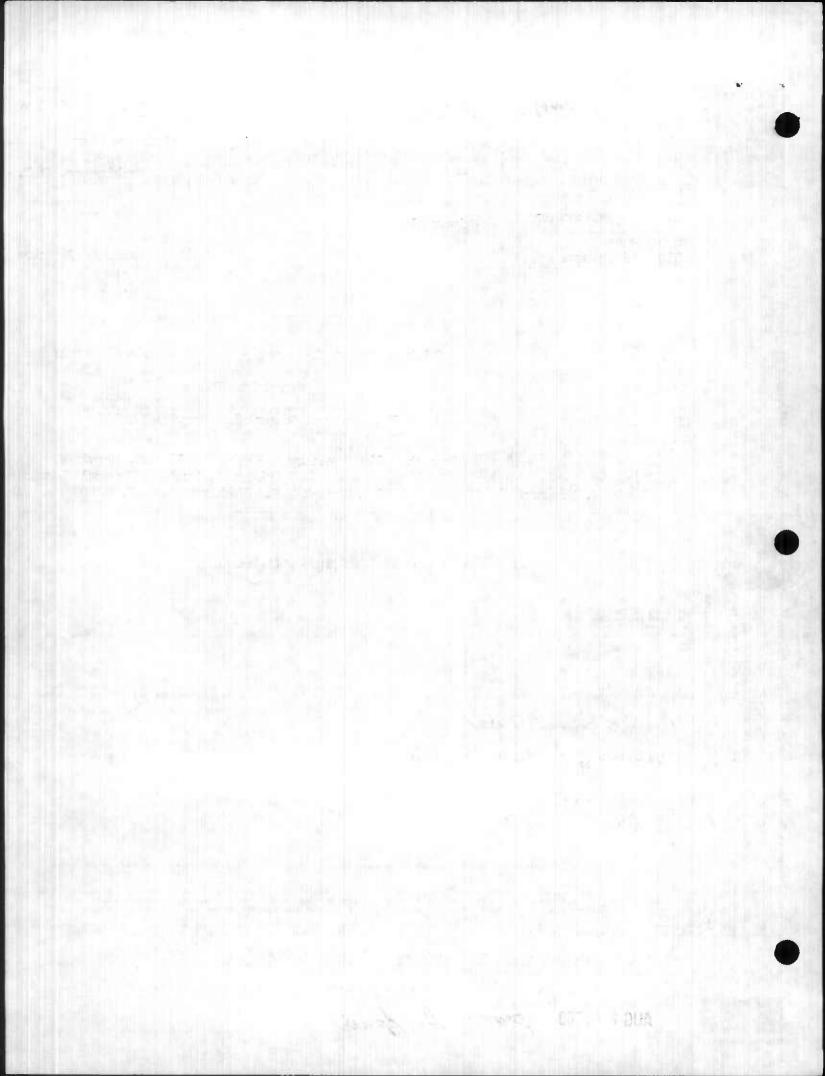
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31. Dete filed (Month, Day, Year) AUG 3 1 2009



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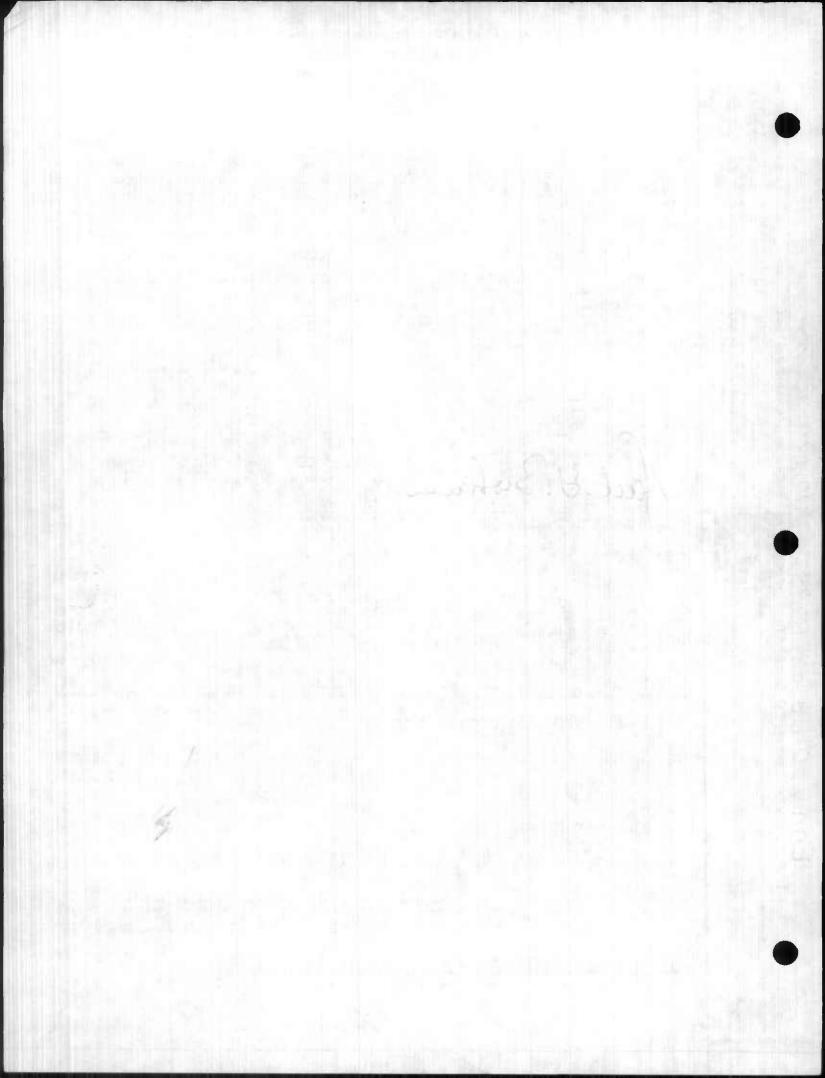
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State of Maryland / Department of Health and Mental Hygiene

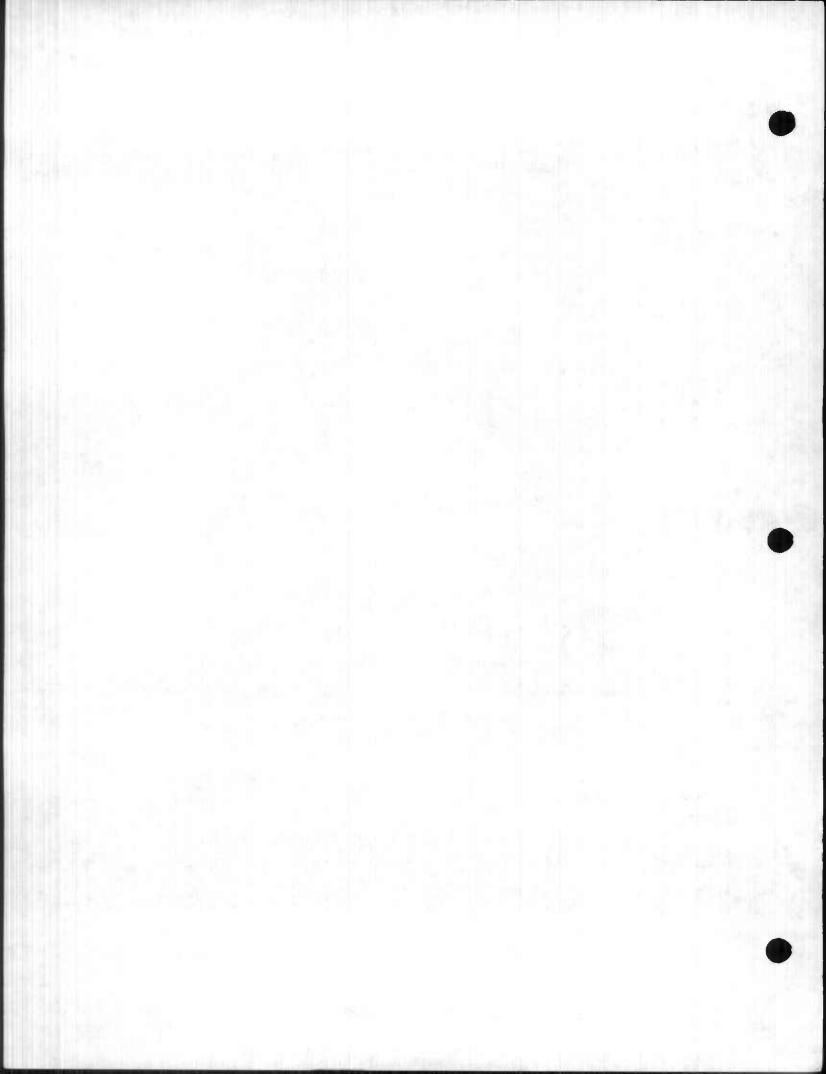
				Cei	tificate of	Death	Re	g. No.	00 2	9270		
100	<b>2</b> 1. 1.1.	Decedent's Nama (First, Middla, Last)						Day	Year 3.	Time of Death		
	Physician /Medical	OLLIE	SUE	ENNI	S		SEPTEMBE			50 AM		
	Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, Town, or Lo	ocation of Deeth	4c. County	of Death			
31		SOUTHERN MARYLAN	D HOSPITAL CE	NTER		CLINTON		PRINCE	GEORGE	'S		
100	Funeral	Social Security Number     6. Se	744 000 5	s. last birthday)	If Undar 1 Yaar Months Days		8. Date of Birth (Month, Day,	Year)	9. Birthplaca Country)	(Stata or Foreign		
	Director	3//-50-4/05	□M 2XD F 83	Yrs.			MARCH 24	,1918	NORTH"C	AROLINA		
	9	Usuel Rasidance of Decedant  10a. Stata 10b. County	10e C	ity, Town or Lo	cation				10d Ir	nsida City Limits		
	sho sho sho	MARYLAND CHARL						☐ Yas 2) No				
	or 28e-f a be notified		-L3									
n	har death or have 23 siner must.	11. Marital Status	12. Was Decedent Evar in Armed Forces?	U,S. 13.	Was Decedent of f Yas, specify Cul	Hispanic Origin? (Sp ban, Maxican, Puerto	ecify Yas or No- Rican, etc.)		ı - Amarican In k, Whita, atc.	dian,		
\$18-0020	Ar, or B	1 Never Married 2 Merried 3 Widowed 4 Divorced	1 ☐ Yes 2 🖒 No If Yas, Giva Yaar or Datas:		I□Yas 2NNo			Specify: WHITE				
7.A.M.	22 ho	15. Decedant's Edu		16a. Deced	tant's Usuai Occu	upation	ina 1	6b. Kind of Bu	sinass/Industr	1		
2 2	Med Alle	(Specify only highast grad Etemantary/Secondary (0-12)	College (1-4or 5+)			a during most of work ed)						
10 2	led within typiene. her then nt, the Me	12		HOMEN	IAKER			OMN HO				
A br	San San S	17. Father's Nema (First, Middle, Last)				18. Mother's Nam			a)			
ON	J Ment	THOMAS F. PARDU		400 44-10	Add (04		A SPARKS		Ctata Zin Cod	(-)		
000 , Maryl	10 2 g	JUDY F. WILLOUGHBY				E DRIVE, L				*		
22	Han office and	20a. Mathod of Disposition	20b.	Placa of Dispo	sition (Nama of natory or other pla	to cont	Data 2	Oc. Location -	City or Town,	Stata		
Om	A THOU	1 Ø Buria 2 ☐ Cremation 3 ☐ 6 4 ☐ Densition b ☐ Other (#pegity)	Amoyal from State			CEM. 09	-06-2000	CHELTE	NHAM. I	MARYL AND		
O	Party of the lands	21. Signature of Fagers Service Ligens	500			NTT FUNERA						
_ =	mew	MADE & BROHA	MOODS 3						2060	14		
2	IIICW	MARK G. BROHAWN M00053 P.O. BOX 156, WALDORF, MARYLAND 20604  23a. Part J Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Approximate interval Batween										
	Physician	Shock of haart failure. List only o						set end Daath				
8	/Medical	Immediate Csusa (Final disaasa or condition	A 6 don	minal Carcinamatosis.  10 (or as a consequence of):  (ic Cachexiz Syndrome Ext						01		
B	Examiner	rasulting in daath)	Dua to	(or as a consec	juance of):				18	129/00		
0	axecuted in and hal-transit Examiner		57	pired								
,0	ne death certificate be associted the attending physician and ched for use as the burial-transit ysician/Medical Examir	Sequentielly list conditions, if any, laading to immadiata cause. Entar Undarrying Cause (Disease or injury that initieted events  Dua to (or as a consequence of):  Dua to (or as a consequence of):  Dua to (or as a consequence of):										
-09	be a sictan buris											
68760	icate be physicla s the but	rasulting in death) Last	Dua to (	or as a conseq	uanca of):				- 10	at 1,00		
S S	nding use a		d						101	so has.		
B	death cer e attendir od for use	Part II. Other significant conditions co	ntributing to death but not re	eulting in the u	ndadvino causa o	aven in Part I	23h Did tol	bacco use cor	tribute to the	cause of death?		
00	by the teche	A a a	Δ	A .		grant not account	1 □ Ye			y 4 □ Unknown		
	signed I be det	Coronary	Witard	Wisc	ise.							
- Dro	cien: The law requires that the death cert artificate has been signed by the attendin scior, page 2 should be deteched for use Be Completed by Physician/W						24a. Was an perform		availab	utopsy findings la prior to		
0 8	aw requ						-2759		comple of deat	ition of cause h?		
~E	yelclen: The lav s certificate has director, page 2 To Be Comp	Saladina (a part					1□ Ya	s 20 No	1 □ Ya	s 2 No		
1 S ital	riffice ctor.	25. Was casa rafarred to medical axaminar?				26. Placa of Deat	h (Check only one	a)				
25	die dire	1 Yas 2 No	Hospital: 1 Inpatiant 2	☐ ER/Outpatier	t 3□ DOA O	Other: 4 ☐ Nursing Ho	ome 5 Residar	nce 6 Oth	ar (Specify)			
5 6	ner th	27. Mannar of Death 1 2 Natural 5 ☐ Pending	28a. Data of Injury (Month, Day Year)	28b. Tima of tnjury	28c. Inj	ury at ork?	28d. Dascribe ho	w injury occur	ed			
Sign	ending eath. or: Atter the fune	2 Accidant investigation			M 1[	□Yas 2□No						
JVI.	after deat Director: I in by the	3 Suicida 6 Could not be 4 Homicide datarmined	28a. Placa of Injury - At building, atc. (Spec	homa, farm, str cify)	aat, factory, office	9	28f. Location (Str. City or Town,		er or Rural Ro	ute Number,		
App	ours ours illed	29a. Cartifier 12 Certifying Phy	sician: To the best of my kn	nowledge death	occurred at the	tima, data and place	and dua to the ca	usa(s) and ma	nner as stated			
7-8	To the Hospital or Attending Pl within 24 hours after death: To the Funeral Director: After it completely filled in by the funera Medical Certification:		ner: On the basis of axamin and mannar stated.									
	within to the comple	29b. Signatura and title of certifiar		ELLA	29c. Licer	nsa number	29	d. Data signe		Year)		
		I ofertion In	H iman	. D.	DE	35295		9/1	100			
		30. Name and address of person who c	ompiated causa of death (tte	em 23a) (Type,	Print) Sat	ish Guman	i					
27.77		10 St. Patrick	s Udr, Svit	< 208	iwal	good p	10 206	003				
	State	31. Data filed (Month, Day, Year)	32. Ragistrar's Sign	nature	1							

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 00 2927

		Certificate of Death	Reg.	No.	9211			
Physician	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Dealt			
/Medical	Ruth Elizabeth Gossard	4b. City, Town, or L	August	4c. County of Death	0950			
Examiner	4a Facility Name (If not institution, give street and number) Washington County Hospital	Hagersto		Washingto	n			
241	5. Social Security Number 6. Sex 7. Age (In yrs. last b.							
Funeral Director	214-09-4381 1 M 2 M F 81	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Dey, Ye June 10,	1919 Penns	sylvania			
yland		wn or Location		10	d. Inside City Lim			
r 28a-f ahow Incollect at	Maryland Washington	Hagerstown			1 ☐ Yes 2 ☐			
vith the Me t or 28s-f s be notified	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Count	ry?			
3a or	17934 Clubhouse Drive	21740		USA				
2 should be filed within 72 hours efter death with the Menyland and Mentel Hygiens. Is marked other than "natural", or frems 23a or 28a-f show sumatic avent, the Medical Examiner must be notified at TO Be Completed by Funeral Director.	11. Maritaf Status  12. Was Decedent Ever in U,S. Armed Forces?  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U,S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Stiff Yes, specify Cuban, Mexican, Puerform 1 Yea 2 \square XNo Specify:	pecify Yes or No- p Rican, etc.)	14. Race - America Black, White, e Specify: W				
uld be filed within 72 hours whenle Hygines than 'natural', wide avant, the Medical Ex- rite avant, the Medical Ex- TO Be Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king 16b	. Kind of Business/Indu				
De de la company	8 0	hairdresser		cosmoto	logy			
2 should be filed with and Mentel Hygiena. Is marked other than aumatic avent, the II To Be Comp	17. Father's Name (First, Middle, Last)		ne (First, Middle, Mail					
Meni Meni To	John Edward Starliper	Lottie	Willard H	ornbaker				
of end 2 should be filed within the the than and Mentel Hygiene.  tem 27 is marked other than other traumatic avent, the 14.  To Be Comp		b. Meiling Address (Street end Number or Ru 17934 Clubhouse Dr.,						
00-	1 & Burial 2 Cremation 3 Chemoval from State	of Disposition (Name of ery, cremetory or other place) Tiew Cemetery		c. Location - City or Tovercersburg,				
pemit. Peg Department Importent: If any Injury o	21. Signature of Funeral Service Licensee	22. Name and Address of Facility 415 E. Wilson Blv		TUNERAL HOM				
	Deor 11/10/comme				Approximate			
Physician	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart tailure. List only one cause on each line.		or reappratory uneat,		Interval Between Onset and Deat			
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  a.   Cordicate  Due to (or es a	consequence of):			111002			
	Cardea	Anny the wine						
tificate be executed to physician and as the burial-transi  Aedical Exami	Sequentially list conditions.  Due to (or as a	consequence of):						
Ex rial	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	11Factor						
ficate be executed sphysician and ts the burial-transit edical Examiner	that initiated events resulting in death) Last	consequence of):		1				
2 00	Corod on Arts							
ettendin for use	4.500, 61, 61, 61	gissue.		1				
deat deat	Pert II. Other algnificant conditions contributing to death but not resulting	in the underlying ceuse given in Part I.	23b. Did toba	cco usa contribute to	the cause of d			
es that the death cer igned by the ettendir be detached for use by Physician/A	Diality: Hyperlipidera;	Calionopothy.	1 Yea	2☑No 3□ Prob	ebly 4 Uni			
been s should leted	Phicadial Willow Fa	Tanyorde	24e. Was an e perlormed	17 ava	re autopsy tindi ilable prior to apletion of caus leath?			
The law page 2			1 ☐ Yes	/	Yea 2□ No			
certificate rector, pag	25. Wes case referred to medical	26. Place of Dea	th (Check only one)					
hysicia his cer ol direc	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/C	Outpatient 3 DOA Other: 4 Nursing H	ome 5 Rasidenc	e 8 Other (Specify	)			
g Physical distribution of TC		Time of 28c. Injury et linjury Work?	28d. Describe how	injury occurred				
ath. rr: After ne funer ation	2 Accident investigation	M 1 Yes 2 No						
al or Atta s attar de il Directo od in by th	2 Accident 3 Suicide 4 Homicide  28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)  28f. Location (Street end Number City or Town, State)							
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After It completely filled in by the funeral Medical Certification:	29a. Certifler (Check only one)  Certifying Physician: To the best of my knowledge and manner stated.	e, death occurred at the time, date and place nd/or investigation, in my opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as sto end place, and dua to	ated. the cause(s)			
M M	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, L				
, , ,	I hele big to	1 2231	3	8-3	35-00			
9,45	30. Name and address of person who completed ceuse of death (Item 23a) ELI POZA M9 - WAJH L		or ritae					
State	31. Date filed (Month, Day, Year) 32. Fegistrar's Signature	& Spark						

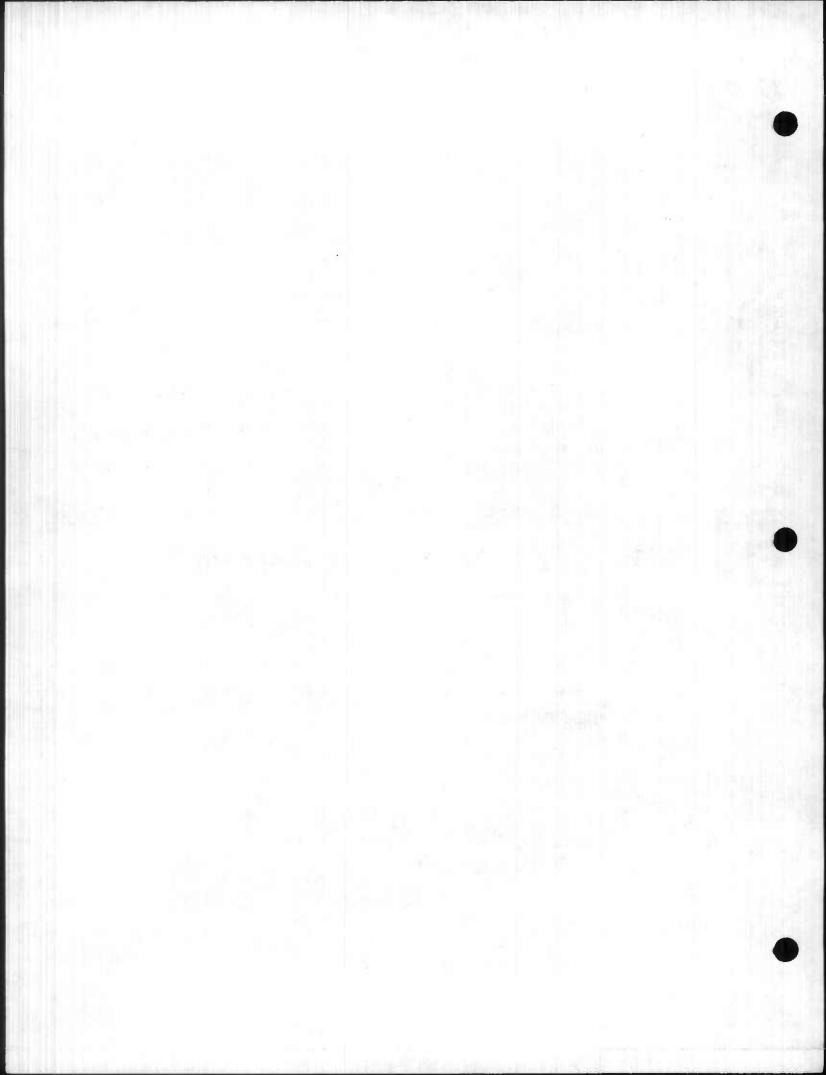


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** Month Year ROBERTA ALTCE GORDON AUGUST 30 2000 0145 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KENT & QUEEN ANNES HOSPITAL CHESTERTOWN KENT If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 DE 214-34-5842 64 October 15, 1935 Pennsylvania Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Caroline Denton 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 10509 Orly Drive 21629 Funeral United States 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Never Married 2 ☑ Married 1 ☐ Yas 2 No If Yes, Give Year or Dates: aitimore. Marviand 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) Colfege (1-4or 5+) 12 Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any Injury or other traumatic event abics. Be George Thomas Parry Mary Ferris Terrill 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Carroll A. Gordon 10509 Orly Drive, Denton, Maryland 21629 Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) White Marsh Cemetery 9/2/00 Trappe, Maryland 21. Signature of Funeral Service Licen MOORE FUNERAL HOME, P.A. Kaudo 125, SECNOST., Denton, Md. 21629 LOONE 23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata tritervat Between Onset and Death Physician Immediate Cause (Final disease or condition resulting In deeth) /Medical CHRONIC LYMPHOCYTIC LEUKEMIA 10 yrs Examiner physician and s the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical Due to (or as a consequence of) Box P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b BRONCHIECTASIS Records, Š 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy DIABETES 2 No 1 ☐ Yes 2 No 1□ Yes certificate Division of Vital Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifica Maly filled in by the funeral director, I 8 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1) Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and titla of certifier 29d. Date signed (Month, Day, Year) D41587 30 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen A. Noble, M.D., 122 Speer Road, Chestertown, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

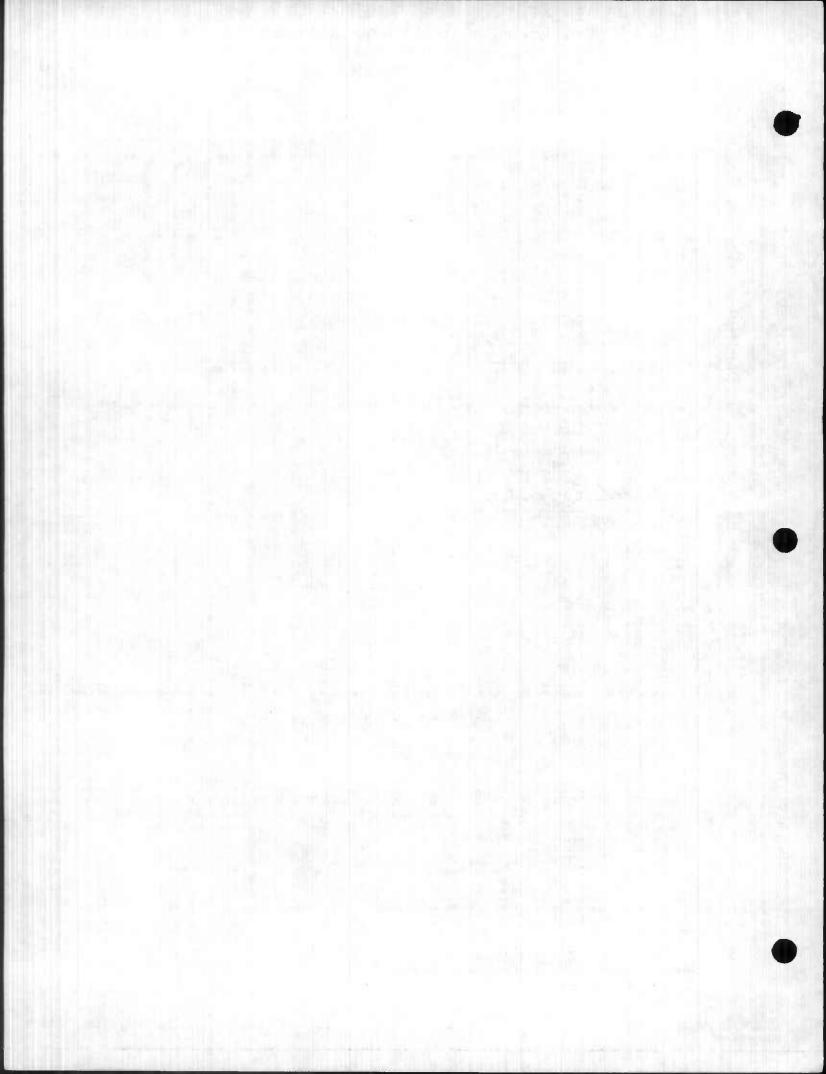
DHMH 16 Rev 6/95

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene 00 29273

	Certificate of Death		Reg. No.	0 60610
	1. Decedent's Nama (First, Middla, Last)	2. Data of D		3. Tima of Death
Physician	Frances Crouse Gaguine	August	26, 200	Yaar 00 10:45 PM
/Medical Examiner		or Location of Dear		
. Adminier	8100 Connecticut Avenue, # 809 Chevy C	hase	Mor	itgomery
neral	5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Under 1 Year   If Under 24	Hrs. 8. Date of Bi		Birthplace (State or Foreign Country)
rai tor	357-14-6999 1 M 2 F 90 Yrs. Months Days Hours	Vin. (Month, D	14, 1910	Country) Missouri
	Usual Rasidence of Decedant	1001001)	11,1310	111000011
	10a. Stata 10b. County 10c. City, Town or Location	-771-1	4-1	10d. fnside City Limita
0	Maryland Montgomery Chevy Chase			1 ☐ Yas 2X No
Director	10e. Street and Number 10f. Zip Coda		10g. Citizen of V	/hat Country?
ត				
-a	8100 Connecticut Avenue, #809 20815	0.40		States
Funeral	11. Marital Status  12. Was Decedent Evar in U.S. Armed Forcas?  13. Was Decedent of Hispanic Origin If Yas, specify Cuban, Maxican, P	uarto Rican, atc.)	Blac	e - Amarican Indian, k, Whita, atc.
by F	1 ☐ Nevar Married 2 Married 1 ☐ Yas 2 M No II ☐ Yes 2 M No Specify:		Specify	White
	3 Widowed 4 Divorced Yaar or Datas:			
ere	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most or	working	16b. Kind of Bu	sinaas/industry
important: If item 27 is marked other than "naturel", any injury or other traumatic event, the lead on East ance.  To Be Completed by	Elemantary/Secondary (0-12) College (1-4or 5+)			
Ö				n Home
Be (	17. Fathar's Nama (First, Middla, Last) 18. Mothar's	Nama (First, Middle	e, Maiden Sumam	a)
To	Harvey Crouse Susan	Amelia (	Cass	
	19a. Informant's Name/Ralationship (Type, Print)  19b. Mailing Address (Street and Number of	r Rural Route Numi	ber, City or Town,	Steta, Zip Code)
	Bruce Alexander Gaguine/Son 516 Bethany Curve, S	Santa Crus	z. Califo	rnia 95060
	20a Method of Disposition 20b. Place of Disposition (Name of	August 29,	1	City or Town, Stata
	1 Burial 2 Cemetary, cramatory or other pleca)		D - 1.1 - 1	
	4 Donation 5 Other (Specify) Montgomery Crematorium, I			la, Maryland
	21. Signature of Funaral Sarvice Licenses  MO0672  22. Nama and Addrass of Facility I Bethesda-Chevy Cl	Cobert A.	Pumphrey	Jiconcin Aven
	M00672 Bethesda, Marylan	id 20814-	-3501	visconsin Aven
Н	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ce shock, or heart failure. List only one cause on each line.	rdiac or raspiretory	arrest,	Approximate Interval Batween
	SHOOK, OF HOUR FAILURE. LIST ONLY ONE GRADE OF BEAUTIME.			Onsat and Death
	Immediata Causa (Finel			
	disease or condition resulting in death) Cardiopulmonary Failure			
-	Dua to (or as a consequence of):  Aortic Insufficiency and Mitral	Posumoi +	ation	
Examiner	b	Reguigita	ation	
Year	Sequentially fist conditions, if any, leading to immediate cause. Entar Undarfying Cause (Disease or injury c.			
	cause. Entar Undarlying Cause (Disease or injury			
5	that initiated events resulting in death) Last Dua to (or as a consequence of):			
Medicai				
210				
Physician/	Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.	23b. Did	tobacco uss cor	ntributa to the cause of death
Juy.	Frailty and Haisht Issa C	, 10	Yes 2 No	3 Probably 4 Unknow
	Frailty and Weight Loss Secondary to Gastric Cancer	and		
Completed by	Gastrectomy	24a. Wa	s an autopsy	24b. Wara autopsy findings available prior to
5	- Casta Colony	per	lormed?	completion of ceusa of death?
-			Van a Man	
			Yas 2 No	1 ☐ Yas 2 ☐ No
D	axaminar? Hospital: Other:	Deeth (Check only		
2	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nurs	ng Homa 5 🕅 Ras		
5	27. Mannar of Death 1 Notural 5 □ Panding 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury at Work?	28d. Dascribe	how injury occur	red
ati	2 Accident invastigation M 1 Yas 2 No			
Certification:	3 Suicide 4 Homicida  6 Could not be datarmined  28a. Place of Injury - At homa, ferm, street, factory, office building, atc. (Spacify)		(Street and Numb own, Stata)	er or Rural Routa Number,
Ser	outling, all (Spanify)			
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and p	place, and dua to the	a cause(s) end ma	innar aa stated.
edicai	(Check only 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death and manner stated.	occurred at tha time	, data and place,	and dua to the causa(s)
Me	29b. Signatura and titla of certifiar 29c. Licensa number		29d. Data signe	d (Month, Day, Year)
	Suran H. Honrew MJ D0019950		August 2	28, 2000
	30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)			
	Susan H. Houseman, M.D., 2100 Pennsylvania Avenue	th Floor	Washing	gton, D.C. 2003
ate	31. Data filed (Month, Dey, Year) 32. Registrar's Signatura			
trar	AUG 2 9 2000 Some B. Spacks			



	State of Maryland / Department of He  Certificate of D		
Physician	Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Yaar  3. Time of Death	
/Medical		5.5 MAN August 30 300 18.38 b. City, Town, or Location of Death 4c. County of Death	
Examiner Funeral Director	THE JOHNS HOPKINS HOSPITAL  5. Social Security Number  6. Sex 7. Aga (In yrs. last birthday)  7. Aga (In yrs. last birthday)  80 Yrs.  Results of the security Number of Number of Number of Number of Number of Number of Number of	Baltimore  Hours Min. Aug. 25, 1920  Baltimore  Baltimore  9. Birthplaca (Stata or Foreign Country)  St. Louis, MO	
Moss	Usual Rasidence of Decedent  10e. Stata 10b. County 10c. City, Town or Location	10d. Inside City Limits	
or items 23s or 28s-f show infract must be notified at y Funeral Director	FL Broward Pompano Beach	Yas 2□No	
al Director	10e. Street and Number 802 Cypress Grove Lane Apt.210 33069	10g. Citizen of What Country? USA	
0	11. Marital Status  1 Naver Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U,S. Armed Forcas?  1 Naver Married  13. Was Decedent of His If Yas, specify Cuban  14. Was Decedent Ever in U,S. Armed Forcas?  15. Was Decedent Ever in U,S. Armed Forcas?  16. Yas Decedent Ever in U,S. Armed Forcas?  17. Was Decedent Ever in U,S. Armed Forcas?  18. Was Decedent of His If Yas, specify Cuban  19. Wa	spanic Origin? (Specity Yas or No- n, Maxican, Puerto Rican, etc.)  14. Race - American Indian, Black, Whita, atc.  Specity: White	
Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  16a. Decedent's Usual Occupat (Give kind of work done do Iffa. DO NOT use retired)  Owner	ation large most of working large most of working large larg	
		18. Mother's Name (First, Middle, Maidan Sumama)	
To Be	Herbert K. Grossman	Sue Silverman	
		Sue Silverman  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 33069 802 Cypress Grove Lane Apt. 122 Pompano Beach, Fi	L
	20a. Method of Disposition  1 St Burlal 2 Cremation 3 St Ramoval from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemeters, crematory or other place South Hill Hebrew	Date 2000, Location - City or Town, State York, PA 17403	
DODGE.	21. Signature of Funeral Service Licensee 22. Name and Address Geiple Fun 53 Main St. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying	neral Home, Inc. t. Glen Rock. PA 17327	
for use es the buriel-transit  Jan/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Antic Requestation learn endournessity in death)  Die to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  C. Dua lo (or as a consequence of):  Dua lo (or as a consequence of):  d	corditis Smonths,	
leted by Physicia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	on in Part I. 23b. Did tobacco use contributs to the cause of death?	,
P	Aprile disection	1 Yss 2 No 3 Probably 4 Unknown	n
Completed by Physician/Me	April disection  Chronic Rual insufficiency	24a. Was an autopsy performed?  24b. Were autopsy lindings available prior to completion of cause of death?	
Eo		1  Yes 2 No 1 Yes 2₽No	
Be	25. Was case referred to medical axaminer?	26. Placa of Death (Check only one)	
70	1 Yas 2 No Hospital: 1 12 Inpatient 2 ER/Outpatient 3 DOA Otha	4 Nursing Home 5 Hesidance 6 Dottlar (Specify)	
Medical Certification: 1	2 Accident investigation M 1 Y	Yes 2 No	7
Certif	4 Homleida detarmined building, atc. (Specity)	City or Town, State)	
Aedical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my op one)	of 28c. Injury at Work?  M 1 Yes 2 No  28f. Location (Street and Number or Rural Route Number,	
¥ ×	Vang, mo. Res-a		
State	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ERTC Yang M.D. 600 NORTH Wolfe STREET  31. Date filed (Month Day, Year)  32. Registrar's Signature	Baltimore, mo 21287	
State gistrar	SEP 1 1 2000 Serve 5. Spark	6	

DHMH 16 Rsv 6/95

ORIGINAL

ETERT IN AND DEPOSITE SERVICE The first of the

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 9 per fh G788 10/20/00 vf Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death **Physician** 8:45 pm GOSLEE 4s Fecility Nama (If not institution, give street and number) 8 29 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner SCHOOL NOTU 11500 -OLO MARDELA SPRINGS
HUnder 24 Hrs. 8. Data of Birth WICOMICO If Under 1 Year 5. Social Security Number 6 Sex Birthplace (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year) Months Days Hours Min. 2/3 -0/ - 7873 Usual Rasidence of Decedent 3 Yrs. MD. 10e State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Director MO WICOMICO MARDELA SPRINGS 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21837 USA SCHOOL 11500 ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 220 No If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: P 3 Widowed 4 □ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC SELF-EMPLOYED WORK 18. Mother's Nema (First, Middle, Maiden Sumema) 17. Father's Nama (First, Middla, Last) Be To HOPKINS BROWN DAMUEL MARIADA BROWN 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LAUREL, DE. 1995

20c. Location - City or Town, Stata RT3 BOX 282 - COLUMBIA RD. DE. 19956 KACHELE. WINDER - DAUGHTER 20b. Plece of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition Dete 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ZION CHURCH CEMETARY 9/2/2000 MARDELA SORINGS, MD. 21. Signature of Funeral Service Licenses 22. Nema and Address of Facility BENNIESMITH F/H 23a. Part 1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrast,

Agent 1 allure. List only one cause on each line. 2/80/ Approximata Intarval Between Onset and Death Immedieta Causa (Final diseasa or condition resulting In death) FAILURE CONGESTIVE HEART YYS Due to (or as a consequence of): HYPERTENSIVE CARDIOMYOPATHY YYS 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CHRONIC RENAL FAILURE 24b. Were autopsy findings aveilable prior to complation of cause of death? 24a. Wes en autopsy performed? HEPATO RENAL DISEASE PULMONARY HYPERTENSION 1 Yes 2 No 1 Yas 2 No 25. Was casa refarred to medical examiner? 26. Place of Death (Check only one)

Department of Heelth and Mental hard and Mental hard mortant: If tem 27 is marken any injury or other? **Physician** /Medical Examiner

**Funeral** 

Director

28a-f ahow

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Nerna 23a

"natural", or

al Hygiene.

h and Mental h

traumatic awant, the Medical Examiner must be notified

Baltimore, Maryland 21215-0020

Examine Physician/Medical p Completed Be edical Certification: To

this After t death. Director: /

۵ Records, Division of Vital Attending after A To the Hospital or within 24 hours aft To the Funeral Di completely filled in

> State Registrar

31. Date filed (Month, Day, Year) AUG 3 1 2000

29b. Signature and title of certifie

1 Yes 20 No

27. Manner of Death
1 Naturel
2 Accident

3 Suicide

29e. Certifier (Check only one)

4 ☐ Homicide

·Dala

5 Pending investigation

6 Could not be

MO

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

29c. License number D0042522

1 Yas 2 No

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 301

00

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

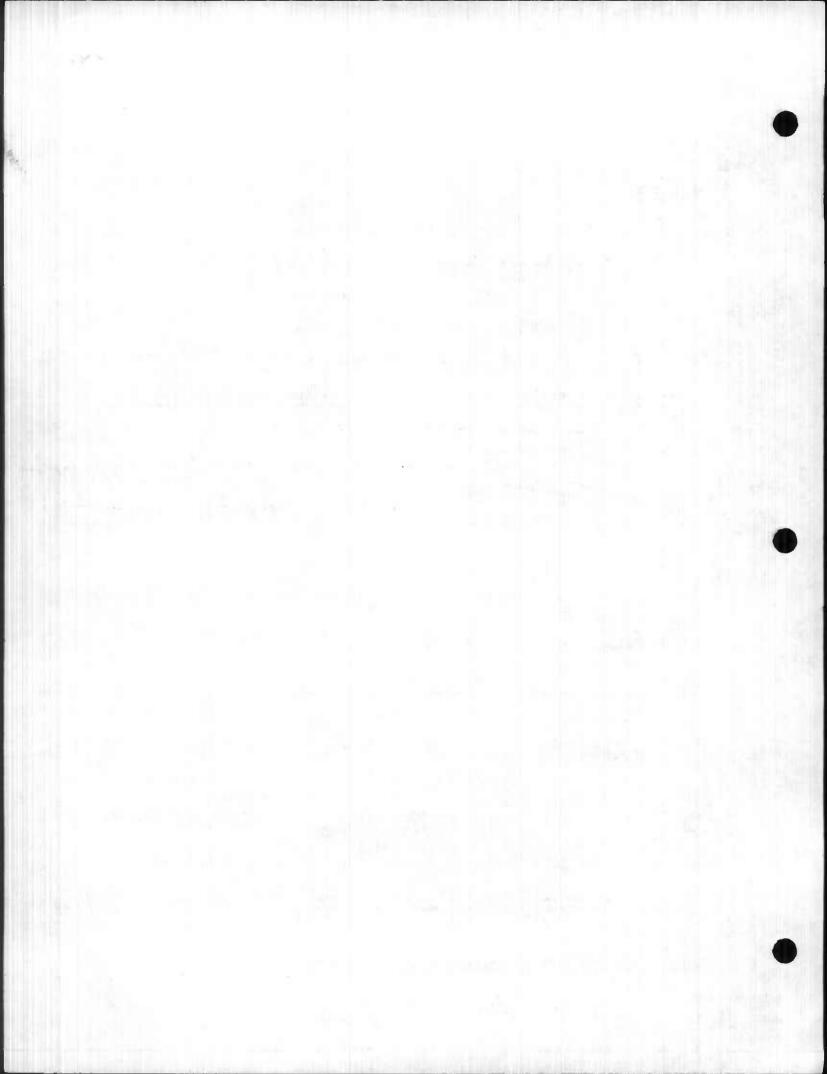
Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Data of Injury (Month, Day Year)

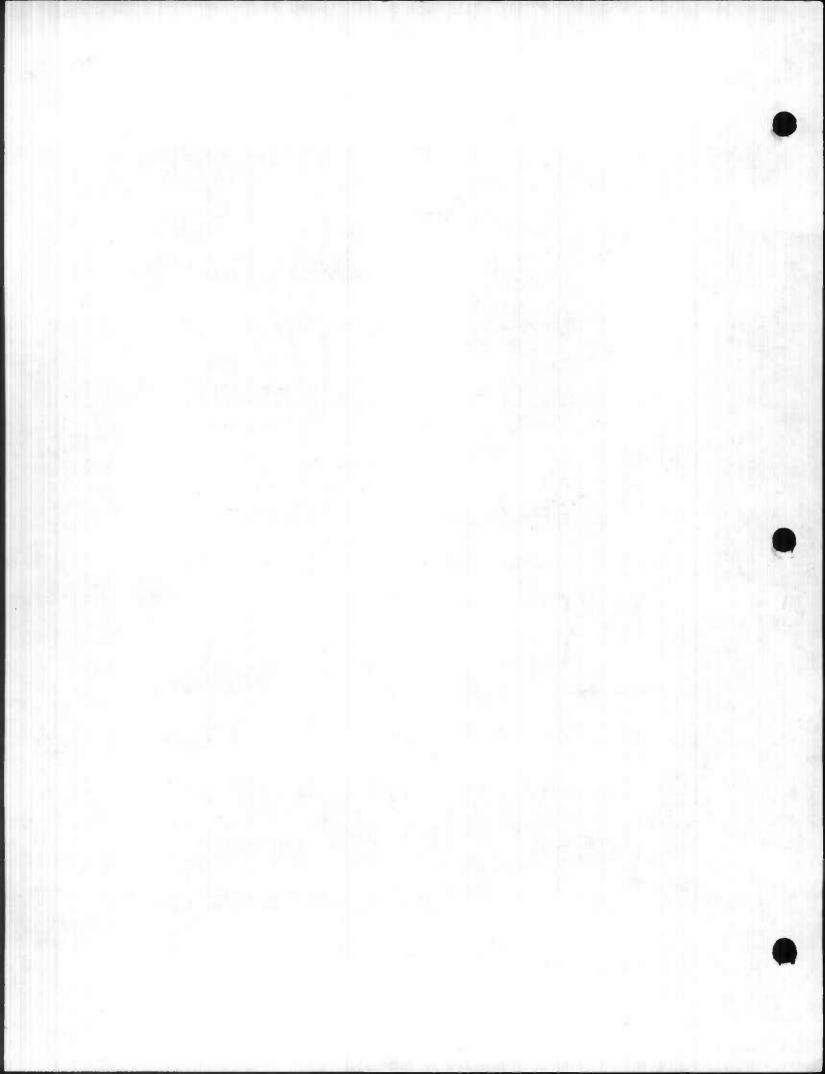
Eastern 614 MD 32. Begistrar's Signatura



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

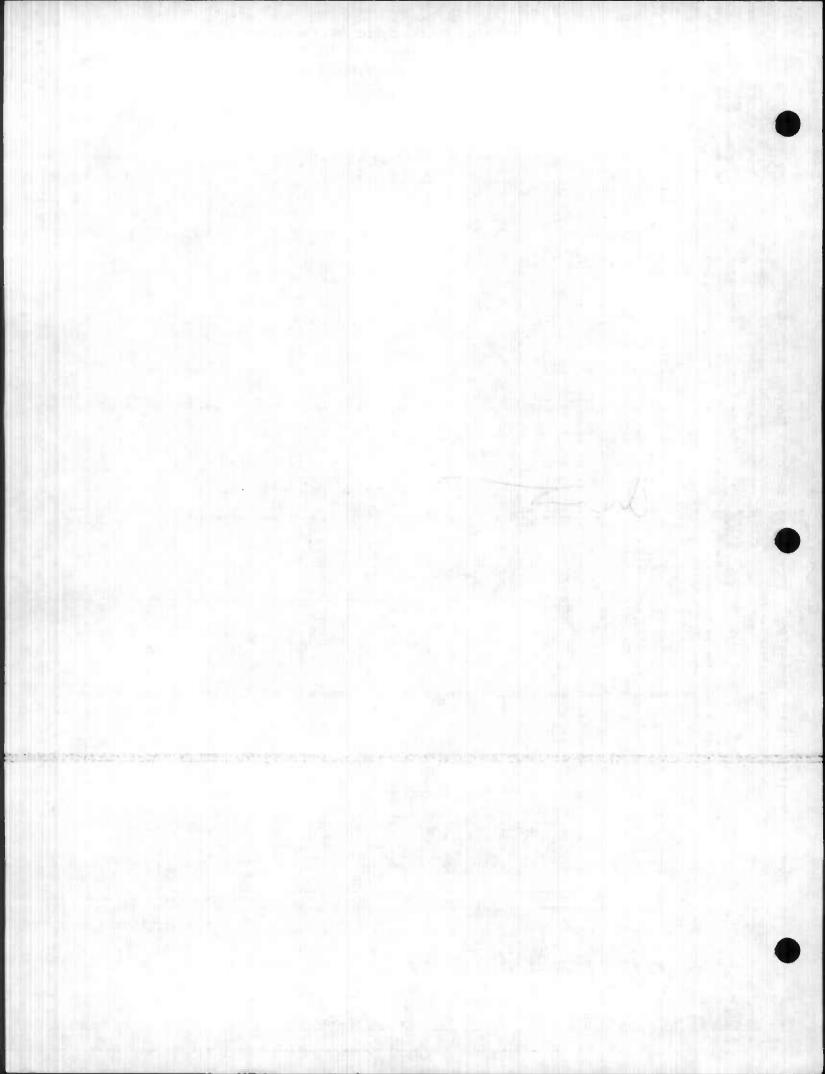
Physician /Medical Examiner  David Carvin Gray  4e Facility Neme (If not institution, give street and number) 2137 Sang Run Road  Funeral Director  Funeral Director  S. Social Security Number 213-26-0817  Garrett  Funeral Director  Funeral Director  Funeral Director  One of Decedent  I Oa. City, Town or Location  I Oa. City, Town or Location  MD Harford  Aberdeen  10c. City, Town or Location  I Oa. City, Town or Location  I Oa. City Town or Locati	te or Fore										
David Carvin Gray  4e Facility Neme (If not institution, give street and number)  2137 Sang Run Road  5. Social Security Number  213-26-0817  Director  David Carvin Gray  4b. City, Town, or Location of Death MCHenry  4c. County of Death MCHenry  4de County of Death MCHenry  4de Facility Neme (If not institution, give street and number)  4de Facility Neme (If not institution, give street and number)  4de Facility Neme (If not institution, give street and number)  4de Facility Neme (If not institution, give street and number)  4de Facility Neme (If not institution, give street and number)  4de City, Town, or Location of Death MCHenry  4de County of Death MCHenry  5. Social Security Number 100	te or Fore										
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Director  213-26-0817  13 M 2□F  69  Yrs. Months Days Hours Min. (Month, Day, Year)  Jan 21, 1931  Virginia  Virginia											
To a. Stete 10b. County 10c. City, Town or Location 10d. Inside MD Harford Aberdeen 10g. Citizen of What Country?  2010 Carsins Run Road 21.001.  11. Meritel Stetus 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  10d. Inside											
MD Harford Aberdeen  10. Street and Number  2010 Carsins Run Road  11. Meritel Stetus  12. Wes Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?)  14. Race - Armerican Indian Bieck, White, etc.	City Lin										
10e. Street and Number 2010 Carsins Run Road 21001.  USA 11. Menitel Stetus 12. Wes Decedent Ever in U.S. Armed Forces?  10f. Zip Code 21001.  USA 11. Menitel Stetus 12. Wes Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-Bleck, White, etc.  14. Rece - American Indian Bleck, White, etc.	'es 20										
2010 Carsins Run Road  21001.  USA  11. Meritel Stetus  12. Wes Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No- Hryes, specify Cuban, Mexican, Puerlo Rican, etc.)  14. Rece - American Indian Bieck, White, etc.											
Armed Forces?  Armed Forces?  If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  Bieck, White, etc.											
1 Never Married 2 Merried 1 XYes 2 No 1 Yes, Give 1 Yes, Give 3 Widowed 4 Divorced Yes or Detes: Korean 1 Yes 2 No Specify: White	•										
3 Widowed 4 Divorced Veer or Detes: Korean White  15. Decedent's Education (Specify only highest grade completed)  Elemantary/Secondery (0-12) 7  16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired)  Elemantary/Secondery (0-12) 7  17. Father's Neme (First, Middle, Last)  18. Mother's Nama (First, Middle, Maiden Surmeme)											
Elemantary/Secondery (0-12) College (1-4or 5+)											
Elemantary/Secondary (0-12)  College (1-4or 5+)  Electrician  Steel Manufactur  18. Mother's Nama (First, Middle, Maiden Sumeme)  Richard Carvin Gray, Sr.  19e. Informent's Neme/Ralationship (Type, Print)  19b. Meiting Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code)	er										
11. Tatilet's Italia (First, Micure, East)											
P Richard Carvin Gray, Sr.  Ophia Madeline Josey  19e. Informent's Neme/Ralationship (Type, Print)  19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
	)1 -										
Joan G. Gray / Wire 2010 Carsins Run Rd., Aberdeen, Maryland 2100  20e. Method of Disposition (Name of cemetary, cremetory or other place)  Date 20c. Location - City or Town, State cemetary, cremetory or other place)											
R = 8   1 ⊠ Buriel 2 □ Cremetion 3 □ Remove from State											
4 Donation 5 Other (Specify)  Bel Air Memorial Gardens 8-24-00 Bel Air, Marylar  22. Name and Address of Facility  McComas Funeral Home, P.A.	10										
McComas Funeral Home, P.A.											
23a. Part 1. Enfar the disease, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or raspiratory errast, shock, or heart failure. List only one drule on each lina.  PicCollas Funeral Home, P.A.  1317 Cokesbury Rd., Abingdon, Maryland 210  Approximation and the death of the country o	nata										
hysician snock, or neert failure. List only one grusse on each lina.	Between nd Deeth										
/Medical Immediate Cause (Finat											
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resulting in death) Lest  Due to (or es a consequence of):											
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24a. Was an autopsy performed? 24b. Wara autop available princompletion	or to										
	2□ No										
25. Was case referred to medical axaminer?  26. Place of Death (Check only one)											
axaminer?    Associated by the control of the contr											
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2 Accident investigation M 1 Yes 2 No											
Suicide  Sui	lumber,										
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.  (Check and Check											
we will be a second at the time, date and place, and due to the caus	sa(s)										
end menner steted.  29c. License number 29d. Dete signed (Month, Day, Yea	r)										
29c. License number 29d. Dete signed (Month, Day, Year H26154 August 20, 2000	11.3										
1/1000											
30. Name and address of person who compiated cause of death (Item 23a) (Type, Print)   Paul Daniel Miller, D.O., Dep. M.E., 69 Wolf Acres Dr., Oakland, MD 21550											
State 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture											
Registrar AUG 2 2 2000 A. Apollo											

DHMH 16 Rev 6/95



AMEND ITS	EMS: #4B-C PER PHY G788	State of Maryl 10-21-00 WR.		partment of t ertificate of		d Mental Hy	giene ()	0 29277			
Physiciar	1. Decedent's Nema (First, Middle, La					2. Date of De Month	Day	Yaar 3. Time of Death			
/Medica	An Franklin Alama Min at In atherina at				4b. City, Town,	August, or Location of Deat		000 4:45 AM of Deeth			
Examine	Casey House				ROCKVII	UE .		OGMERY			
Funeral Director	5. Sociel Security Number 6. S 019-12-6167	Sex 7. Age (In I	yrs. last birthda 80 Yrs.	Months Deys		Min. (Month, Da	th ly, Year) 21,1920	9. Birthplace (State or Foreign Country) Massachusetts			
P	Usuel Residence of Decedent  10a. Stata 10b. County	100	. City, Town or	1 ocation				10d. Inside City Limits			
Maryle f sho				1X Yes 2 No							
death with the Maryla erre 23e or 28e-f shor ir must be notified at	10a. Street and Number		10g. Citizen of V	Vhat Country?							
State of the control	4706 Kemper St.		U.	S.A.							
_ 2 2 2 0		12. Was Decedenf Evar Armed Forcas? 1 🔯 Yes 2 🗌 No If Yas, Give Yaer or Datas:	in U,S. 13	3. Was Decedent of If Yas, specify Cub 1 ☐ Yas 2 ☑ No		? (Specify Yes or No uerto Rican, etc.)	Specify	a - Amarican Indien, kk, White, etc. White			
5-0 72 ho	15. Decedent's E. (Specify only highest gra		16a. Dec	cedent's Usuel Occu ve kind of work done	petion	working	16b. Kind of Bu	usiness/Industry			
vithin the Man	Elamantary/Secondary (0-12)	College (1-4or 5+)	life	al Model I	9d)	working .	Def	ense			
and 2	17. Father's Neme (First, Middle, Last)	)				Name (First, Middle Steinman	, Meiden Sumen	(e)			
laryla 2 should and Mar a marks a marks	19e. Informent's Neme/Reletionship (	Type, Print)	19b. Ma	niling Address (Stree		or Aural Route Numb	er. City or Town.	State, Zip Code)			
	Leslie Alan Golds					lle Mead,					
5 - T 18	20e. Method of Disposition 1 □ Buriel 2 □ Cremation 3 🗵	Removal from State	b. Pleca of Dis cametery, c	position (Neme of remetory or other pla	100)	Dete Aug. 29	20c. Location -	City or Town, Stete			
Itimo	4 ☐ Donation 5 ☐ Other (Specification 21. Signature d Funaral Service Licer	(v) C	ld Mont	efiore Ce		2000	St. A	lbans, NY			
B Page	21. Signature del unavai service cicer	1300		Danzansky	-Goldbe	rg Memori	_				
	23e. Pert1. Emer the diseesa, or com shock, or heert feilure. List only	plications thet caused the one ceuse on each line.				ike, Rock rdiac or respiretory e		D 20852  Approximete Intervel Between Onset and Deeth			
Physician /Medical Examiner	Immediate Ceuse (Finel disaese or condition resulting in death)	е	tic Pro	state Car	cinoma			10 Years			
P = 5		b	10 (01 63 6 0011	sequence or,							
OX 68760, certificate be executed adding physician and use as the burlal-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury	Due	to (or es e cons	sequenca of):		LA		E E E B E H			
58760, icata be ex physician s the burial	that initiated events										
ox 68 certifica nding ph use as th	rasulting in death) Lest										
the state of the s		0.									
P.O. hat the detach detach		ontributing to death but not		Yes 21 No	ntribute to the cause of deeth?  3 Probably 4 Unknown						
Coro			Hath				an autopsy ormed?	24b. Were eutopsy findings available prior to completion of cause of death?			
						10	Yes 21 No	1 ☐ Yes 2 ☐ No			
Vitai   piclan: The centificate irector, pa	25. Wes case referred to medical					Death (Check only	one)				
This all di		,	2 ER/Outpet	ient 3L DOA		ng Homa 5 Res					
noting ath. r: Afte	27. Menner of Deeth 1 \( \omega \) Neturel 5  \text{Pending} \\ 2  \text{Accident}  \text{investigetion} \\ 3  \text{Suicide}  6  \text{Could not b} \\ 4  \text{Homicide}  \text{determined} \end{array}		At home, ferm,	M 1	Yes 2 No	28f. Location	(Street and Numb wn, Stete)	er or Rural Route Number,			
DIVIS  To the Hospital or Attention 24 hours after de To the Funeral Directo completely filled in by it	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	yaician: To the best of my niner: On the basis of exar									
within To the comple	29b. Signature and title of certifier	( ) stoled.	1	29c. Licen	se number		29d. Dete signe	d (Month, Day, Year)			
15	Mars a	1 200	ec t		37620		Aug.	27, 2000			
	30. Name add oddress of person who Mark S. Godec, MD				r Mill	Rd Rock	ville. M	D 20855			
State	24 Date filed (Month Day Year)	32. Registrar's S		- /							

DHMH 16 Rev 6/95



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 2 9 2 7 8

				ificate of	Death		leg. No.	0 2	2610	
Physician	Decedent's Name (First, Middle, Last)     ANN CAREY HE					2. Date of Dea	Day	Year 2000	7:40PM	
/Medical Examiner	4e Facility Name (If not institution, give :	4b. City, Town, or	SEPTEM Location of Death	4c. County		7 . 401 M				
	GREATER BALTIM	ORE MEDICA	L CENT.	ER	TOWS	ON	BAL	TIMOR	E	
Funeral Director		7. Age (In yrs. 86	· last birthdey)Yrs.	Months Days		8. Date of Birth (Month, Day Aug. 1		9. Birthplace Country) Maryl	e (State or Foreign and	
2	Usual Residence of Decedent  10a. State 10b. County	10c. C	ity. Town or Loca	ation				10d.	Inside City Limits	
Haryti Fed at Ior									XXYes 2□No	
or 28a-f s or 28a-f s be notified Director	10e. Street and Number			10f. Zip Code		10g. Citizen of V	Vhat Country	?		
her death v Nerne 23e Inter must Furneral	1717 Aberdeen R	t. E Vi D Loch Hav	illage	2123	34		USA			
		12. Was Decedent Ever in t Armed Forces? 1 ☐ Yes 2 【XNo If Yes, Give Year or Detes:	J,S. 13. W	les Decedent of Yes, specify Cut	Hispanic Origin? (S ban, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Blac	- American k, White, etc.		
Popularian Popularian	15. Decedent's Educ		16a. Decede	ent's Usuet Occu	pation		16b. Kind of Bu	islness/Indua	try	
of within 72 hours at yours at yours at yours that yours that to be Medical Exam Completed by I	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give ki	ind of work done  O NOT use retire	pation during most of world)	rking				
212 Danie de la companie de la compa	Liementary/Secondary (0-12)	3	Secret	ary			State &	Count	ty Govt.	
Maryland 42 should be file th and Mental My 7 is marked othe beaumelic event To Be C	17. Father's Name (First, Middle, Last) Charles J. Carey	, M.D.			18. Mother's Nar	ne (First, Middle, Ridgely	Maiden Sumem	e)		
Range and Same	19a. Informant's Name/Relationship (Type				at end Number or Ru			State, Zip Co	ode)	
- 5965	Charles Carey He				Dr. Balt				0.11	
altimore mil. Pages 1. partment of He portent: if Hen r Hijury or oth	20a. Method of Disposition  Surial 2 Cremation 3 R		Place of Disposi cemetery, creme	atory or other pla	ece)	Date	20c. Location -	City or Fown	, State	
time tant pary	4 Donation 5 Other (Specify)	St	1		pal Cem.		Berlin,		21811	
Sal Sal	21. Signeture of Funeral Service License	2		Name and Addr			<b>William</b>			
40268	1 XIII K	Julale-			Funeral		erlin, M	1D 2	1811	
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complishock, or heer failure. List only or immediate Cause (Finel disease or condition resulting in deeth)	SEPS			119, 0001 00 001000			Int	oproximate terval Between nset and Death	
D # C		PNEUI	MONIA	4						
60, be assouted ician and burial-transit	0.									
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events  Due to (or as a consequence of):  RESPIRATORY FAILURE  Due to (or as a consequence of):									
5 s s s s	resulting in death) Last									
X 6		HYPOT	ENSION	NIN	JACULA	R DEG	ENER	ATION		
deeth certificate at the deeth certificate at		Tion Units		/			W. C.			
P.O. de by the detache	Part It. Other algorificant conditions con  DEPRESSION	23b. Did tobacco use contribute to the cause of			/					
Division of Vital Records, P.O or Attending Physician: The law requires that the after death.  Director: After this certificate hes been signed by the funeral director, page 2 should be detached in by the funeral director. Page 2 should be detached in by the funeral director.						24a. Was perfo	an autopsy med?	availa	autopsy findings able prior to letion of cause ath?	
Vital Recicles: The law certificate hes birector, page 2 s						101	es 2 DNo		'es 2□ No	
m: T ifficat ov. pd	25. Was case referred to medical				26. Place of De	ath (Check only o				
Of Vita Physician: this certific ral director,	avaminar?	lospital: 1 [Inpatient 2 [	BR/Outpatient	3 DOA	ther:	tome 5 ☐ Resid		er (Specify)		
Physer this seral di	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Inje			now injury occur		The state of	
Vision C Attending P or death. ector: After t by the funeral	1 Dentaturat 5 Pending investigation	(worth, Day rear)	tnjury		Yes 2 □ No	The same				
Divis all or And all Directo ad in by th	3 Suicide 6 Could not be determined	28e. Place of Injury - At the building, etc. (Special	nome, farm, stree	et, factory, office		28f. Location (S City or Tox	Street and Numb m, Stete)	er or Rural R	Poute Number,	
Division of To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:		ilclan: To the best of my kn er: On the besis of examin and manner stated.								
To the within To the Comp	29b. Signeture and title of certifier	2:		29c. Licer	35916		29d. Dete signe	d (Month, De	y, Year)	
	30. Nama and address of person who con RICHARD KIM, MD	mpleted cause of death (Ite	m 23e) (Type, P	ST. STE	4902, B	ALTIMOR	EMD	) (20°	Y	

DHMH 16 Rav 6/95

State

Registrar

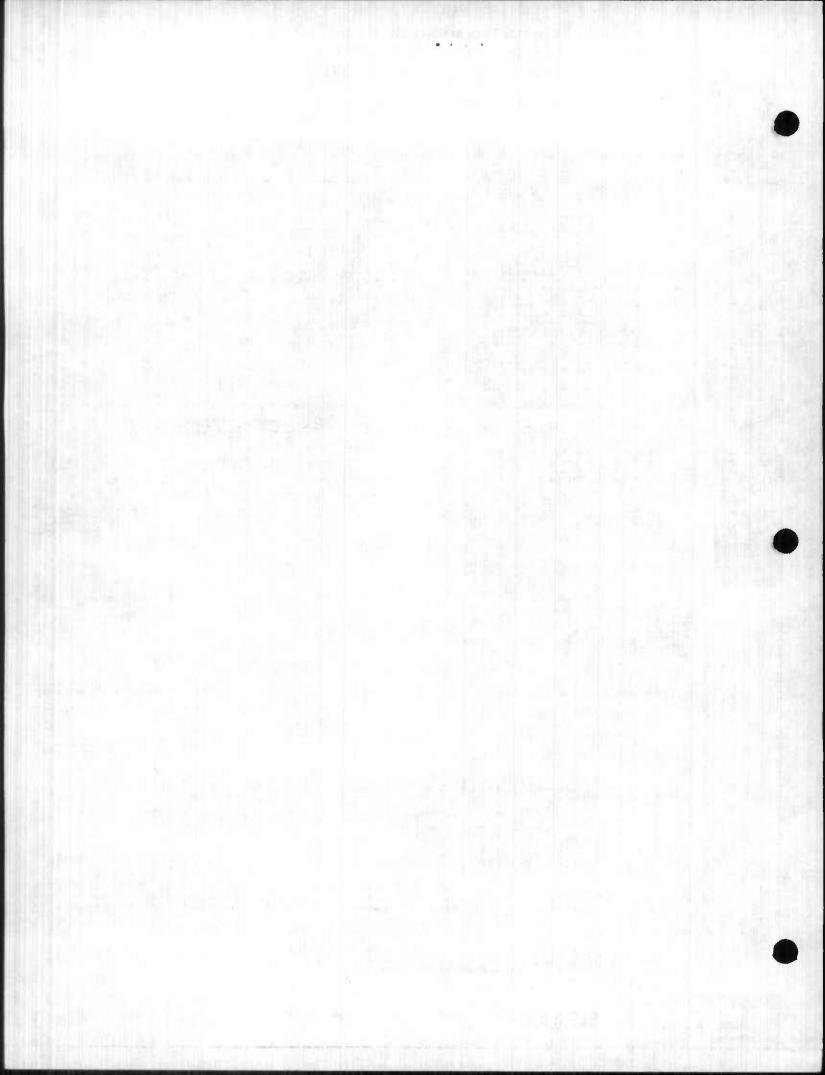
31. Date fited (Month, Day, Year)

SEP 0 6 2000

Heintzelman, Ann

NAME:

5. Sparks



# Baitimore, Maryland 21215-0020 HIRSCH, RICHARD

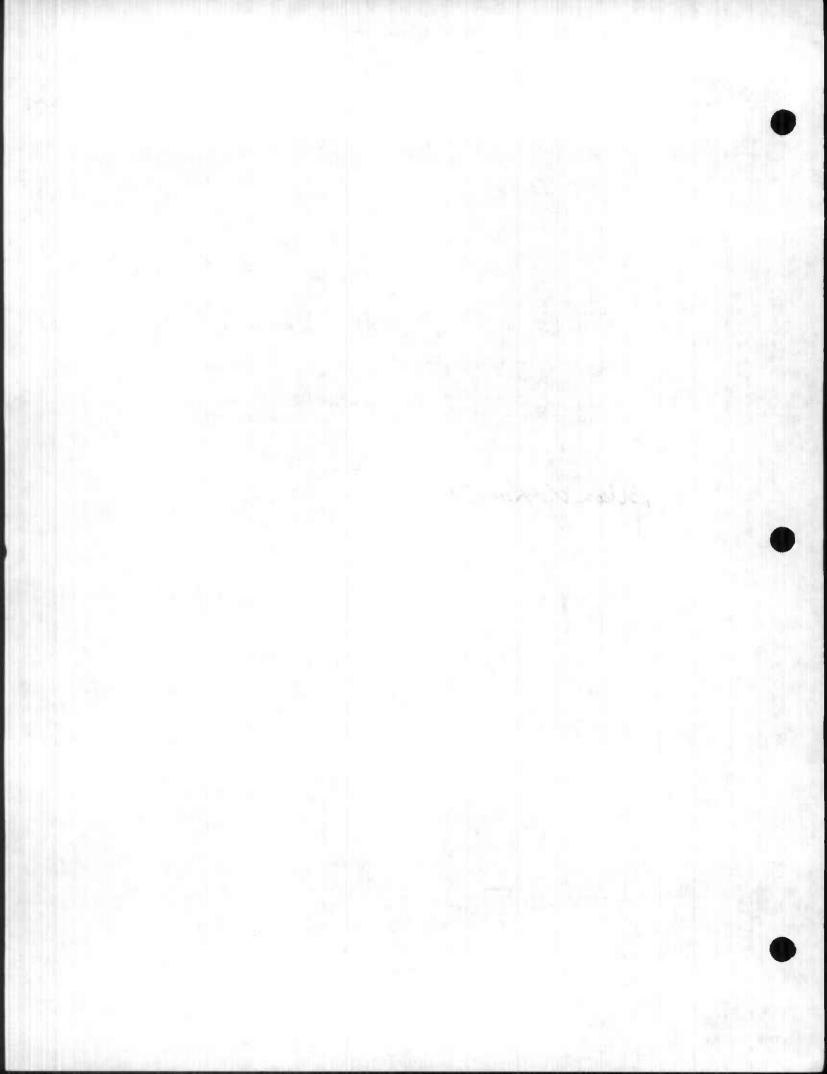
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death RICHARD TIMOTHY HIRSCH Year **Physician** 6:55 AM 29, 2000 AUGUST /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Sinai Hospital of Hunder 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Months 65 Nov 8, 1934 Ohio Director Usual Residence of Decedent 10c. City. Town or Location
Marriottsville 10e. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hyglene. Important: if Itam 27 is marked other than "natural", or Itama 23s or 28s-f show eny Injury or other treumatic evant, the Medical Examinar must be notified as Baltimore 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 11425 Reisberg Lane 21104 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No tf Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married specify: White 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Educetion (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) fireman/paramedic Emergency Med. Service 17. Father's Name (First, Middle, Last) Christopher Hirsch 18. Mother's Name (First, Middle, Meiden Surneme) Florence Leak 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Mrs. Hazel Hirsch (spouse) 11425 Reisberg Ln., Marriottsville, MD 21104 20b. Place of Disposition (Name of cemetery, crematory or other place)
Wards Chapel UMC Cem. 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, Stata 9-2-2000 Randallstown, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHaight Funeral Home & Chapel 21. Signature of Funeral Service Licensee P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical 1 week Sepsis Examiner Due to (or es a consequence of): Examine New tropenia attending physician and for use as the burlet-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Chemotherapy
Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Leukemia 6months Myelogenous Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? mes Phiciency 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Inknown by 24b. Were autopsy findings aveilable prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 XNo 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 Sinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred if or Attending P. after death. 1 Natural 2 Accident 5 Pending investigetion 1 Yes 2 No 3 Suicide 6 Could not be determined Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a Certifier 1 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier August 30, 2000 RESDOO MD 2401 West Belvedere Ave 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAN MD Sinai Hospital of Baltimore Baltimore, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Denema

Registrar

AUG 3 0 2000



00-4803-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. JVW Amended Item#24a perMEOG788 10/16/2000 EW Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** AUGUST 23, 2000 02:30 A.M. Edwin Ashley Horn /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner N/A GOOD SAMARITAN HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number Birthplace (State or Foreign Country) 7. Age (fn yrs. last birthdey) **Funeral** 10XM 20 F Deys Hours Min. 94 Yrs. 213-05-9532 Maryland Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No Yes 2 No N/A Directo **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Herne 23a 7110 Chambers Rd 21234 United States Funeral 12. Wes Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Merried b Maryland 21215-0020 1 ☐ Yes 2 No Specify. White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry flad within Elementery/Secondary (0-12) College (1-4or 5+) Vending Distributor Distribution 6 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) marked of ed bluode George Kimble Horn Florence Adele Maguire and 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Health em 27 i Joelle Kutsiukis / daughter 901 West 33rd St. Baltimore, MD 21211 Baltimore, 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Pages 1 ☐ Burial 2 ② Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 6 Chesapeake Crematory, Inc. 8/26/00 Beltsville, MD 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility CAFA Stephen D. Lohmann, P.A. 8717 Green Pastures Dr., Towson, MD 21286 23a Part He the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** tranediete Cause (Finat diseese or condition resulting in deeth) /Medical Acute Myocardial Infarction Examiner Due to (or as e consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initioted events resulting in death) Last Due to (or es a consequence of): and use as the Due to (or es e consequence of): Part II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? P.0. eu signed by 1 | Yee 2 | No 3 | Probably 4 | Unknown Records, by 8 24b. Were autopsy findings eveilable prior to completion of cause of death? page 2 should edical Certification: To Be Completed 24a. Wes an eutopsy performed? INSPECTION -17 Yes 2 No 1 ☐ Yes 2 ☐ No After this certificate of Vital 25. Wes case referred to medical 26. Plece of Deeth (Check only one) examiner?
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2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and placa, and due to the cause(s) and menner stated. 29e. Certifier completely

Registrar **DHMH 16 Rev 6/95** 

State

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29b. Signeture end title of certifier

31. Dete filed (Month, Day, Year)

Stephen Radentz,

AUG 2 8 2000

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

M.D.

32. Pagistrer's Signeture

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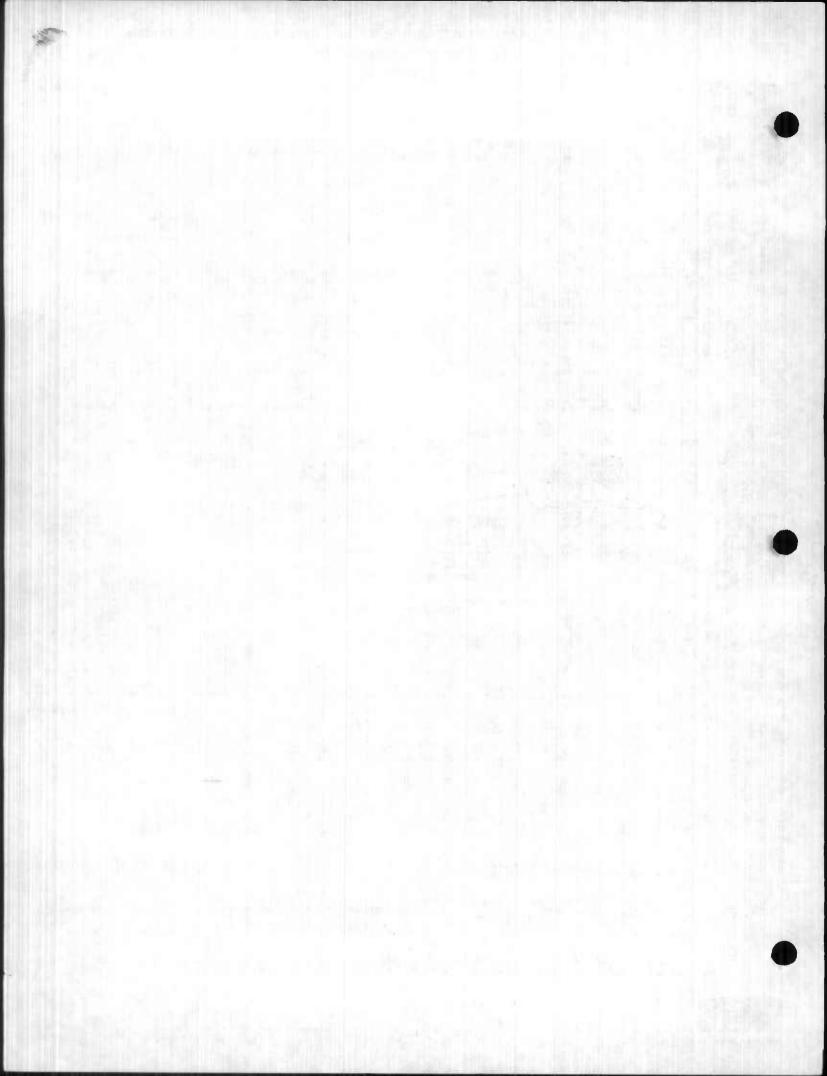
29c. License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

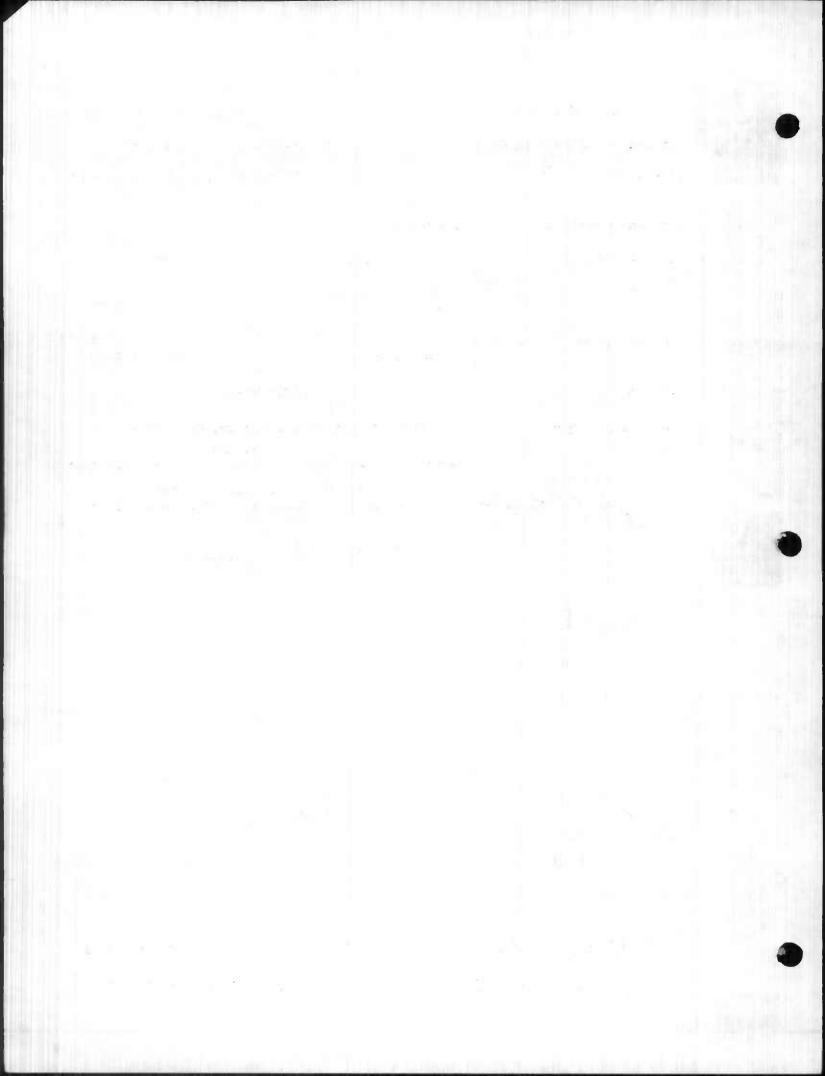
AUGUST 25, 2000



State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Roy B. Johnson 1435 August 28 2000 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Memorial Hospital Easton
If Under 1 Year | If Under 24 Hrs Talbot 8. Data of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Feb. 21, 1941 Maryland 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 59 Yrs. 215-38-1824 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits literna 23s or 28s-f show MD Federalsburg Caroline 1 Yes 2 No Funeral Director the Medical Examiner must be notifie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 26330 Williamsburg Road 21632 United States 14. Race - Amarican Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 b 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Blacktop Plant Supervisor Construction 10th 18. Mothar's Name (First, Middle, Maiden Surnama) 17. Father's Name (First, Middle, Last) Be Bernice Gillis Sewell Hunter Johnson 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 6 3 2 19a. Informant's Name/Ralationship (Type, Print) important: If item 27 is any injury or other traus once. 26330 Williamsburg RD, Federalsburg, Miriam T. Johnson/Spouse Baltimore, 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 20a. Mathod of Disposition Date Pages 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Federalsburg, MD 9/2 Hill Crest Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Framptom-Hawkins-Eskow Funeral Home, P.A Federal sburg, Maryland 21632, P. 0. Box 43

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast,

Approximate Holocole Approximate Interval Between Onset and Death Physician Immediata Causa (Final disaasa or condition resulting in death) /Medical Cerber VASCULAN Examiner Due to (or as a consequence of): Physician/Medical Examiner > 10 YRS Seveno CARDONINA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated evants use as the burial-trai The law requires that the death certificate be execu Box 68760, that initiated evants resulting in death) Last Dua to (or as a consequence of): P.O. be detached Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? page 2 should Be Completed this certificate has 1 Yas 2 No 1 ☐ Yes 2 ☐ No lal or Attanding Physician: The state death.

al Director: After this certificated in by the funeral director, pi 25. Was case referred to medical 26. Piace of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 28d. Describe how injury occurred Medical Certification: 27. Manner of Death 28c. Injury at Work? Division 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completaly filled in 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

Johnson

Roy

AUG 2 9 2000 DHMH 16 Rev 6/95

29b. Signature and litle of certifier

K. BRUZ 31. Date filed (Month, Day, Year)

HELMU 403 MURUEL 32. Registrar's Signature

30. Name and addrass of person who completed cause of daath (Item 23a) (Type, Print)

29c. Licansa number

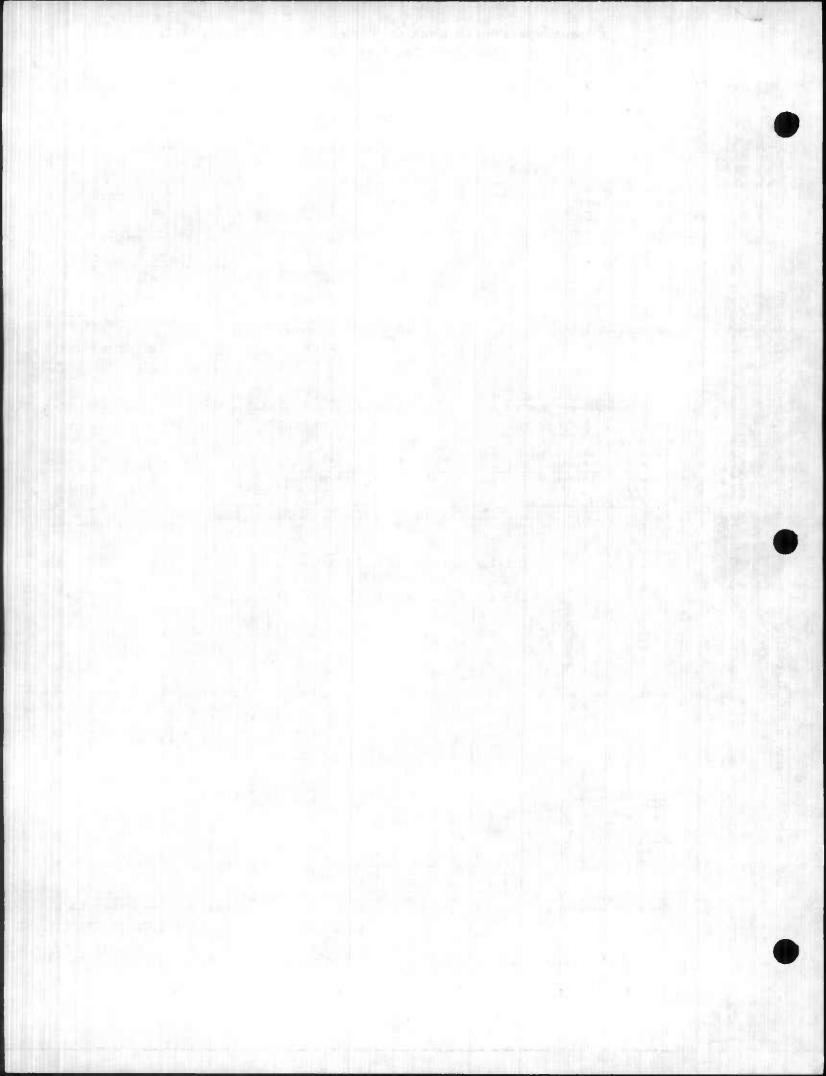
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29d. Date signed (Month, Day, Year)

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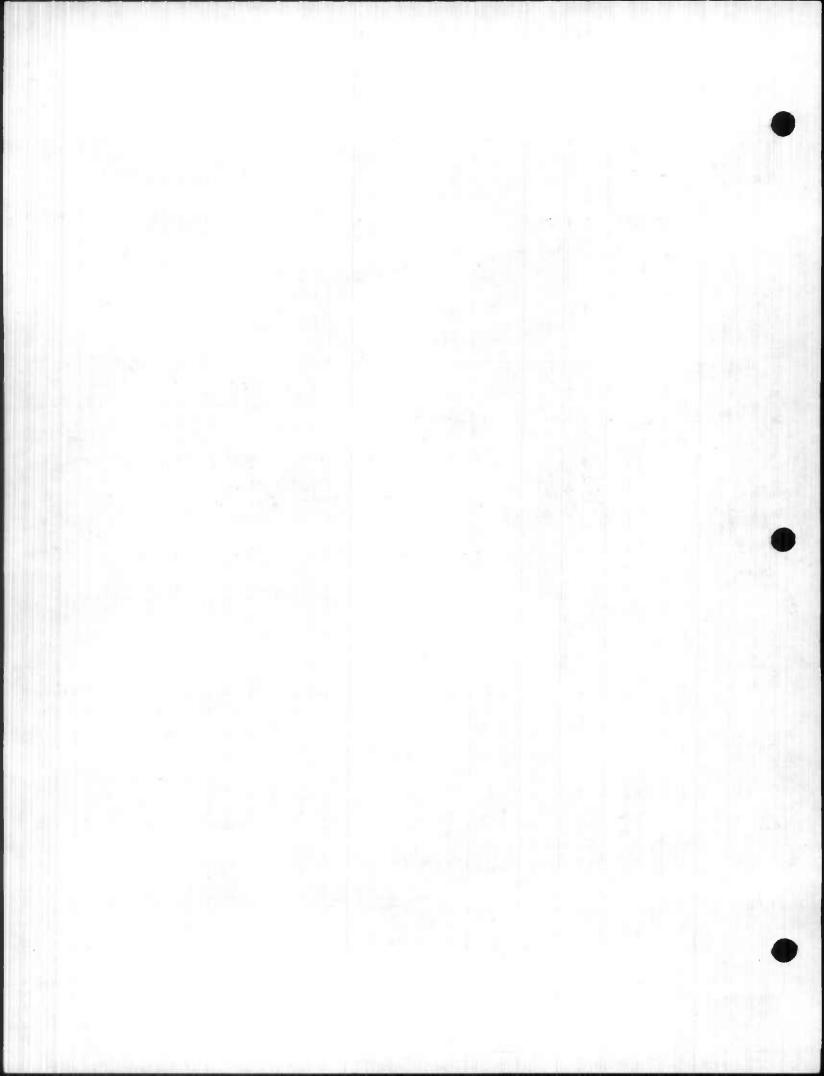


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** 22 2000 3:45 A.M. George Bruce Jackson August /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Forest Hill Mariner Health of Forest Hill Harford If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Days Months Hours 1⊠M 2□ F Director 143-01-2607 3, 1916 New Jersey Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location rait, or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 1 Yas 2 No Director **MARYLAND** HARFORD FOREST HILL 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 FOREST VALLEY DRIVE 21050 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 72 hours after XIX Never Marriad 2 Married 21215-0020 1 Yes 2 No Specify: Specify: P 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled Baltimore, Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be George Wallace Jackson (u/k) (u/k)Anna 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other to Dr. David Jackson Nephew 1631 Wyatts Ridge, Crownsville, MD 21032 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 8 1 ☐ Buria 2 1 Cremation Hilltop Service Corp. on 5 Doyley (Specify) 8-24-00 Towson, Maryland 21. Signature of Furieral \$ 22 Name end Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line Approximate Interval Between Onset and Death **Physician** CEREBRAL VASCULAR ACCIDENT /Medical Immediate Cause (Final disease or condition resulting in deeth) **Examiner** Due to (or as a consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Due to (or as a consequence of): Pert II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? o a. 1 Yes 2 No 3 Probably 4 Unknown Records, þ Pe e 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 PNo certificate 1 Tyes 2 No of Vital Attending Physician: 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Division 1 Diatural 5 Pending 1 Yas 2 No 24 hours after death.

Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 D Homicide ò Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 \$ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Andew Nowalings mo AVGUST 22, 2000 D08096 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ANDREW NOWAKOWSKI ND 125 N. MAIN ST. BECOM, MD21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature State oaks Registrar AUG 2 4 2000

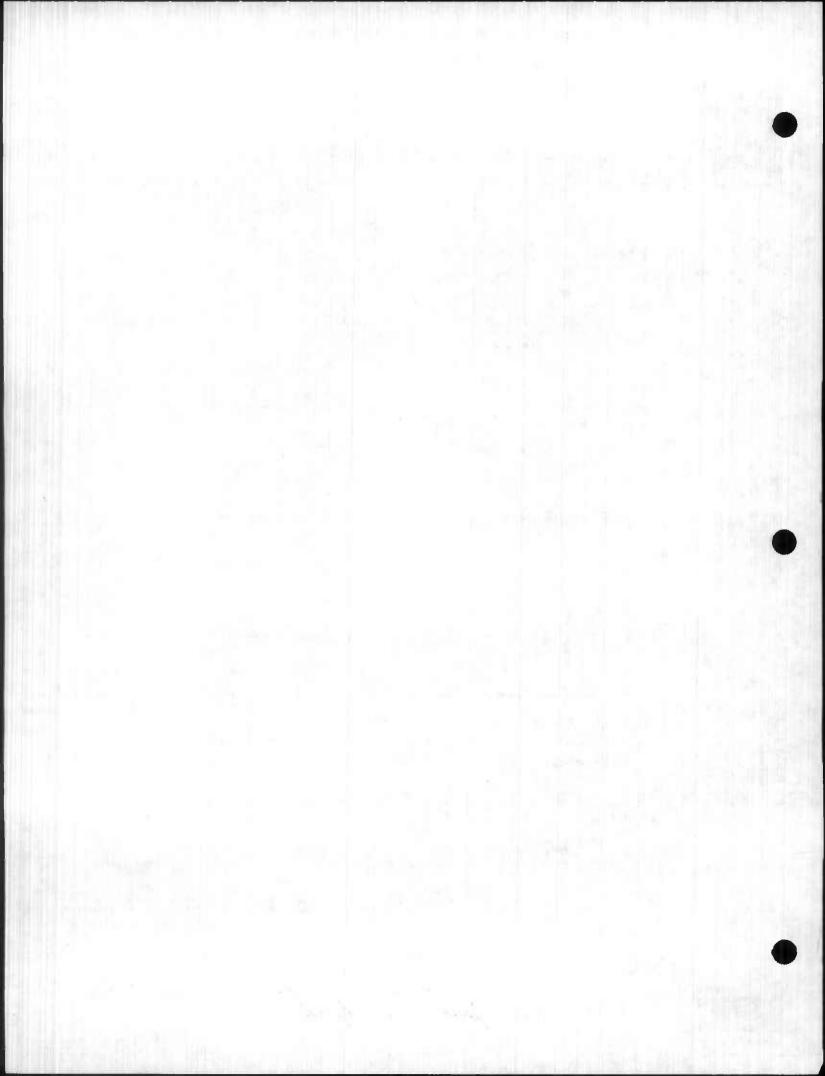
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State of Maryland / Department of Health and Mental Hygiene

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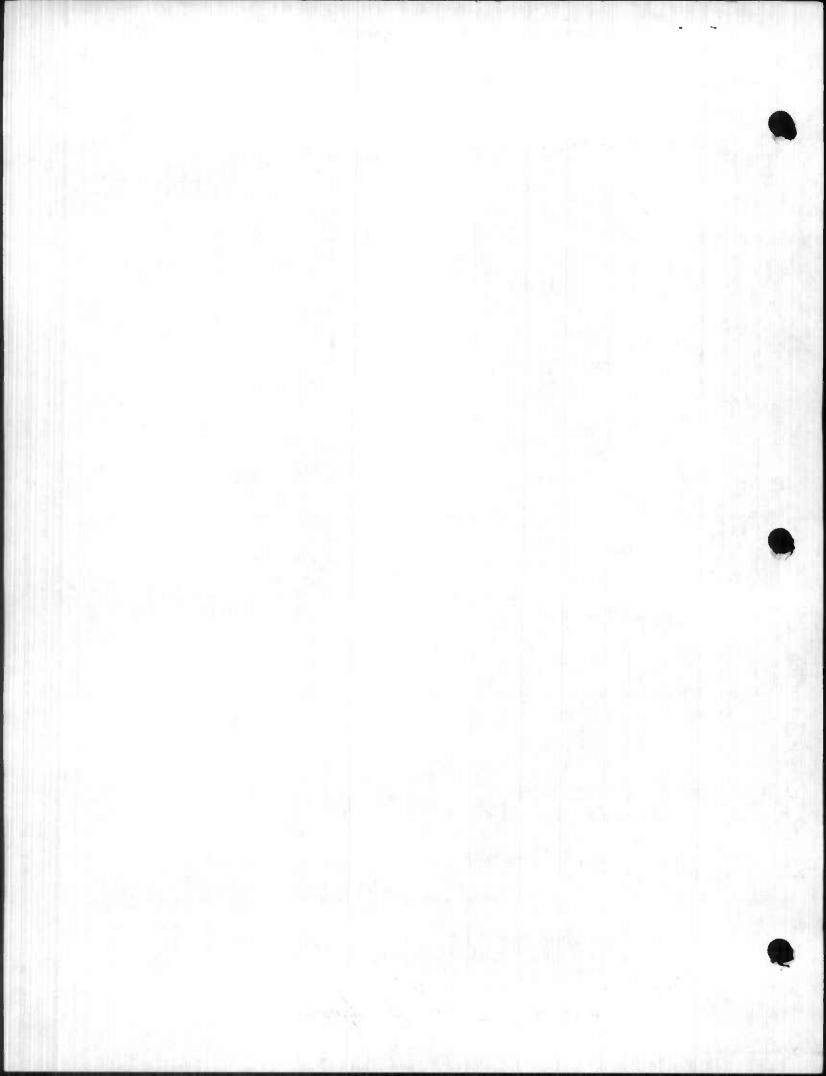
						Ce	ertificate	of I	Death			Reg. No.			. 0
Physic /Med		1. Decedent's Ner Charles	me (First, Middle, 1 S Warren		er						2. Dete of De Month AUGUS	t Dey	Year 2000	3. Time (	of Deeth 15 p.M
Exam		4a Facility Name Washing	(If not institution, g gton Coun							Hag	erstown	n W	ashing	ton Co	).
Funera Directo		5. Social Security 578–42–4	1223	. Sex 1⊠M 2□F	7. Age (In yrs.	last birthda 59 Yrs.	Months	Year Deys	If Under Hours	24 Hrs. Min.	8. Date of Bir Month, Di July	20,193	9. Birth	plece (Stete ntry) ginia	or Foreign
death with the Maryland rns 23e or 28e-f show	ctor	Usuel Residence of 10a. Stete	10b. County	rton Co.		y, Town or lagerst								10d. Inside (	City Limits
th with th	al Director	10a. Street and Number 10f. Zip Code 21742									10g. Citizer	U.S.A.			
5 22	by Funeral	11. Meritel Status  12. Wes Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 12. Yes, Give 14. Divorced  14. Wes Decedent Ever in U,S. Armed Forces?  15. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 15. Yes, Give 17. Yes, Give 17. Yes, Give 17. Yes 2 No Specify:							n, Puerto	ecify Yes or No Rican, etc.)		Race - Ameri Bleck, White pecify: W.			
Maryland 21215-0020 d.2 should be illed within 72 hours after th and Mental Hygiene. 7 is marked other than "natural; or to traumatic event, the Medical Example traumatic event, the Medical Example.	Completed	(Spe Elementery/Sec 1.2		Education		16e. Dec (Gin life.	edent's Usuel re kind of work DO NOT use ne Ass	done i	during mos d)	st of work	ing		of Business/Ir k Manu		rer
Aaryland 212 2 should be filled with and Mental Hygiene, is marked other than reumatic event, the	To Be C	17. Fether's Neme (First, Middle, Last) Willard Lauck Kiblinger  18. Mother's Neme Edna Nac									meme)				
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0 8025			sposition Competion 3 Under (Specific Specific S		State	emetery, cr	position (Neme emetory or oth aven Ce	er pled	,	S	Date Sept.1		tion - City or T erstown		yland
Baltime permit. Pag Department Important: It any Injury o		21. Signeture of	Funeral Service Lic	ensee	ing	I	22. Name end Douglas 1331 Ea	A.	Fier	v Fu	neral N., Hag	Home erstow	m, Mar	yland	21742
Physician /Medica Examined	r	Immediate Cause disease or condition resulting in death)	ion	e.	Vm	or es a cons	odel	Ls	25	0		hor	e !	Interval Bronset and	
ox 68760, conflicate be assented inding physician and use as the burial-transit	n/Medical Examine	Sequentielly list c if any, leeding to i ceuse. Enter Und Ceuse (Disease of that initiated even resulting in deeth)	or injury	c			equence of): equenca of):								
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P.O.	y Physician	Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did to							Yes 2/3	No 3□ Pro	obably 4[	Unknown			
aw requin	Completed by										24a. Wa	s an autopsy ormed?	9	Vere autops valleble prio ompletion of death?	rto
ate h age											10	Yes 204	NO 1	☐ Yes 2	□ No
of Vital Physician: The Physician: The rail director, page	Be	25. Wes cese refe exeminer?		Hospitel:				Oth	her:		th (Check only		700 10		
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= x2 ± =	Certification:	3 Suicide 4 Homicide  City or Town, Stete)  286. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)  287. Accident 288. Location (Street and Nu City or Town, State)								Number or Ru	rel Route Nu	mber,			
To the Hospital of within 24 hours a To the Funeral ocompletely filled	edical	29a. Certifier (Check only one)		Phyeiclan: To the aminer: On the b and man											o(s)
Tota	M	29th Striature an	d title of certifier	(	n/	lh	29c.	Licens 2	se number	23		29d. Date :	signed (Month	Dey, Year	Pivo
		50. Name and add	Kas	o completed ceu	11110	Me	e, Print)	Co	amp	220	Rd	HAG	. Me	1 21	742
Senis	tate	31. Date filed (Mo.	orth, Parisand	1 2000 32. F	Registra's Signe	eture	19 1	100	als	,		,			



State of Maryland / Department of Health and Mental Hygiene 00 29285

	Certificate of Death	Reg. No.			
Dhi-i	Decedent's Neme (First, Middle, Last)	2. Date of Death Month Day, Year	3. Time of Deal		
Physician /Medical	Edgar Charles KEMP	September 4 2000	1 1 1 1 1 1 1 1 1		
Examiner	4a Facility Neme (If not institution, give street and number)  4b. City, Tov	wn, or Location of Death 4c. County of Dec	eth		
	Washington County Hospital Hagers	stown Washing	ton		
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) If Under 1 Yeer II Under 2	24 Hrs. 8. Date of Birth 9. Bi	rthplece (State or For		
Director	705-10-4694 110 M 2 F 89 Yrs. Months Days Hours		aryland		
	Usuel Residence of Decedent  10s. Stete 10b. County 10c. City. Town or Location				
ehow of all	10a. Stele 10b. County 10c. City, Town or Location		10d. Inside City Li 1 ☑ Yas 2 □		
28e-1	Maryland Washington Hagerstown				
or 2	10e. Street and Number 10f. Zip Code	10g. Citizen of What C	country?		
234	431 Cook Street 21740	U.S.A.			
Rema marrim Uner	11. Marital Status  12. Wes Decedent Ever in U,S. Armed Forces?  13. Wes Decedent of Hispanic Original If Yes, specify Cuben, Mexican	gin? (Specify Yes or No- , Puerto Rican, etc.) 14. Reca - Am Bleck, Wh			
by F	1 Never Married 2 Merried 1 Yes 2 No No HYes, Give 1 Yes 2 No Specify:	Specify			
	3 ☐ Widowed 4 ☐ Divorced Yeer or Detes:	Specify. W	hite		
her than "natural",  the Madical Ext  Completed by	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most life. Do NOT use retired)	of working 16b. Kind of Business	s/industry		
	Elementery/Secondery (0-12) College (1-4or 5+) life. DO NOT use retired)				
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- P I M		r's Neme (First, Middle, Meiden Surname)			
	Edward Charles Kemp Catl	herine Hartle			
7 is marks traumatic To	19a. Informant's Neme/Reletionship (Type, Print)  19b. Melling Address (Street end Number	or or Rural Route Number, City or Town, State,	Zip Code)		
27 I	Mildred V. Kemp - Wife 431 Cook Street 1	Hagerstown, Maryland	21740		
20	20e. Method at Disposition 20b. Place at Disposition (Name of cemetery, cremetery or other place)	Dete 20c. Location - City o	r Town, Stata		
	1 □ Burial 2 1\( \text{Cremetion} 3 □ \text{Removel from State} \\ 4 □ Donetion 5 □ Other (Specify) \\ Hagerstown Crematory	9/5/00 Hagerstow	n. Marvla		
mportant: h any injury o	21. Signature of Funeral Service Licensee 22. Neme end Address of Fecility		-		
SE SO	M5 E. Wilson	Blvd. Hagerstown, Ma			
	- Darin Mankuk		Approximete		
	23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart feiture. List only one cause on each line.	ourdide of reapprotory effect,	Interval Betwee		
ysician ledical	Immediate Cause (Finet R. 1 Land R.		F1.		
aminer	disease or condition resulting in death)  a. Diateral Dronchophel	monde	2 days		
-	Due to (or as a consequence of):	N.	1 =		
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clan end buriel-transit al Examir	Sequentially list conditions, Due to (or es a consequence of):				
	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury c.				
s the buria	thet initiated events resulting in death) Last Due to (or as e consequence of):				
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page 2 should be c		24e. Was an eutopsy performed?	. Were eutopsy findi available prior to		
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After funer	1 Naturel 5 Pending (Month, Dey Year) Injury Work?				
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Direct Jin by	4 Homicide determined building, etc. (Specify)	City or Town, State)			
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between Director: After to be the funers blately filled in by the funers edical Certification:	29e. Certifier  (Check only  (C	a piece, and due to the ceuse(s) end manner of the occurred et the time, dete end place, and du	us stated. us to the cause(s)		
To the Funeral Direction of the Funeral Direct	one) end menner steted.	20d Data size of Africa	oth Day Vass		
200	29b. Signeture end title of certifier  29c. License number	29d. Date signed (Mod	nuri, Dey, Year)		
	Valey Smilly Monal Mysician 1) Och:	507 Jep 5	2000		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	141			
	Robert Brull 1459 Potomac Ave, Hagereton	in 116 21742			
State	31. Date filed (Month, Day, Year) 32. Registrer's Signature				
State	CED OC 2000 A Server & Sports				

**DHMH 16 Rev 6/95** 



### Piease Type or Print in Biack Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year ROY ELLSWORTH LUSHBAUGH 4b. City, Town, or Location of Dead 4 Pm 28 00 4a Facility Name (If not institution, give street end number) 4c. County of Death Hagerstown Washington County 11919 Phylane Drive H Under 1 Year H Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Sept. 22, 1921 9. Birthplece (Stete or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 1 3M 2 F Maryland 78 Yrs. 214-09-6544 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Washington Co. Hagerstown 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 11919 Phylane Drive 21742 Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Never Married 2 X Married 1 XYes 2 No 1939-If Yes, Give 1 Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1945 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) State Government Electrician 11 18. Mother's Name (First, Middle, Maiden Sumame) 17, Father's Name (First, Middle, Last) Harry Ellsworth Lushbaugh Ida May Bryan 19a. Intormant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11919 Phylane Drive, Hagerstown, Maryland Vernie V. Lushbaugh, Wife 20c. Location - City or Town, State 20b. Plece of Disposition (Name of Dete 20a. Method of Disposition emetery, crematory or other place) 1 XBurial 2 □ Cremation 3 □ Removal from Stete Cedar Lawn Memorial Park Aug. 31 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service License 22. Name and Address of February Funeral Home 1000 Unmerhale 1331 Eastern Blvd. N., Hagerstown, Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lawing. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) 700 Lyn phone Due to (or as a consequence of): Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence ot): Due to (or as a consequence of) Part It. Other atgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

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**Funeral** 

Director

"natural", or flams 23s or 28s-1 show the Medical Examiner must be notified at

with the Maryland

permit. Plages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygene, important if frem 27 is mental Hygene.

and injury or other traum.

Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Physician/Medical þ cate hes been sig Completed or Attending Physician: Be edical Certification: To this To the Mospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun-

Division of Vitai Records, P.O. Box 68760

								performed?	psy	available prior to completion of cause of death?		
								1 🗆 Yes 2	No	1 Yes 2 No		
25. Was case reterred to medical axaminer?							28. Plece of De	ath (Check only one)				
		Hospitat	1 ☐ tnpatient 2 ☐	ER/Outpatient	3□	ome 5 Residence 6 Other (Specify)						
2 Accident	5 ☐ Pending Investigation		Dete of Injury (Month, Dey Year)	28b. Time of Injury	М	28c.	Injury at Work? 1 Yes 2 No	28d. Describe how Injury occurred				
3 ☐ Suicide 6 ☐ Cou	6 Could not be determined	28e.	Plece of Injury - At h building, etc. (Speci		et, fact	28t. Location (Street end Number or Rurel Route Number, City or Town, Stete)						
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29c. License number

29d. Date signed (Month, Day, Year)

Campus Rel. Hagerstown MD.

2.29.00

State Registrar

**DHMH 16 Ray 6/95** 

29b. Signature and title of certifier

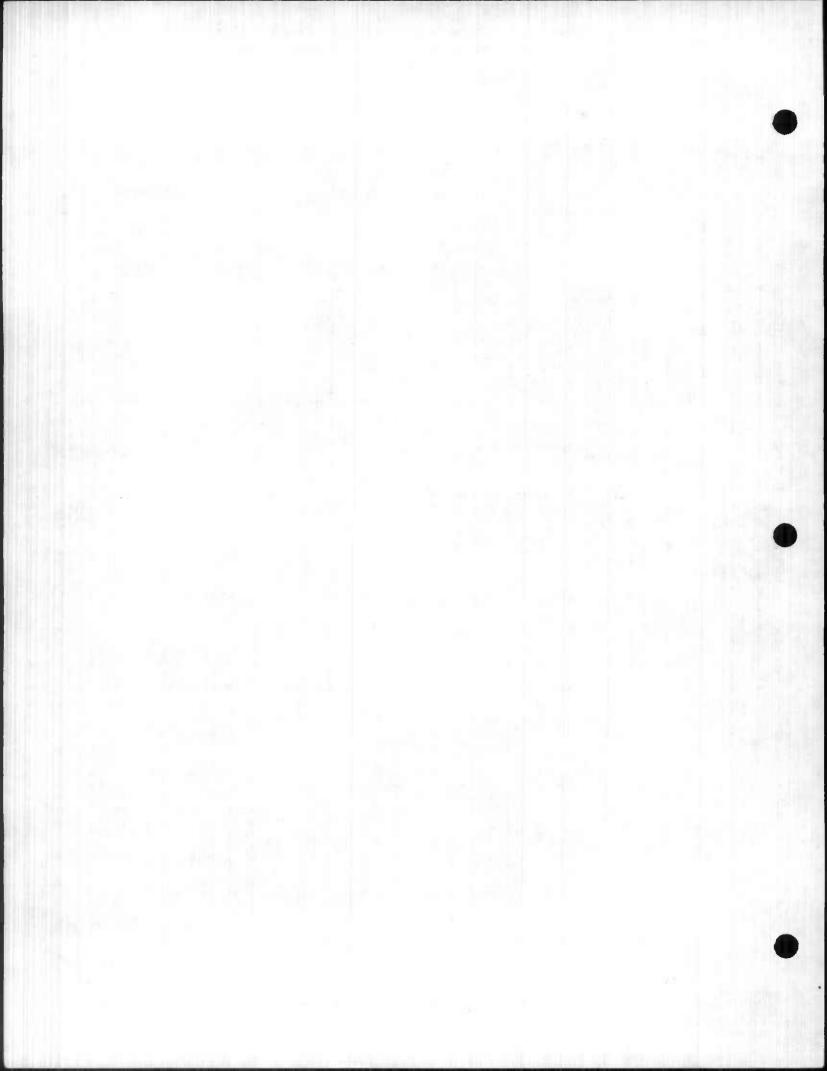
31. Date tiled (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cormack

2000 Registrer Signeture

11110



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death August 26 2000 **Physician** Herbert Clyde Lewis 1955 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (if not institution, giva street and number) 4c. County of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year Months Days 8. Data of Birth (Month, Day, Year) NOV. 1, 1923 If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** 1⊠M 2□ F Hours 194-16-4546 76 Yrs. Director Pennsylvania Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Maugansville MD Washington Co. 1 ☐ Yes 2 No Director 288-7 must be notifi 10g. Citizen of What Country? U.S.A. 10a. Street and Number 10f. Zip Code ð 21767 13735 Village Mill Drive 238 Funeral Dema. 11. Marital Status Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. the Medical Examiner Black, White, etc. 72 hours after 1 Yes 2 No If Yas, Give Year or Datas: 1 ☐ Never Married 2 ☐ Married 21215-0020 b 1 ☐ Yas 2 ☒ No Specify: White Specify: h 3 Widowed 4 Divorced "nathural". Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene, ent. If Item 27 is merked other than 1 Hygene. College (1-4or 5+) Elementary/Secondary (0-12) Truck Manufacturing Machine Operator 0 12 altimore, Maryland 18. Mother's Nama (First, Middle, Maiden Sumama) Twila Mary Striver 17. Fathar's Nama (First, Middla, Last) Be Frank Robert Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 13735 Village Mill Drive, Maugansville, MD 21767 M. Lorraine Lewis/Wife 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Removel from Steta Department of Important: If any Injury or Rest Haven Cemetery Aug. 29 Hagerstown, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, that cause on each line. Approximata Intarval Between Onset and Death Physician Immediata Causa (Final diseasa or condition rasulting in death) /Medical 6 Weeks a. glioblastoma multiforme Examiner Due to (or as a consequence of) Examiner The taw requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events, securities in death). burial-tran Due to (or as a consequence of): and Box 68760 physician Physician/Medical that initiated events resulting in death) Last the Due to (or as a consequence of): . 080 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital Attending Physician: funeral director, 25. Was casa referred to medical 8 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yas 2 No this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending invastigation 1 Netural after death. 1 Yas 2 No 2 Accident 6 Could not be 3 Suicida 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Routa Number, City or Town, Stata) filled in by 4 Homicide 6 Hospital of 24 hours a Funeral C Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data end place, and due to the cause(s) and menner stated. within 2 29b. Signatura and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) 0 2000 26. 30. Nema and addrass of person who completed causa of death (Item 23a) (Type, Print)

**DHMH 16 Rev 6/95** 

State Registrar

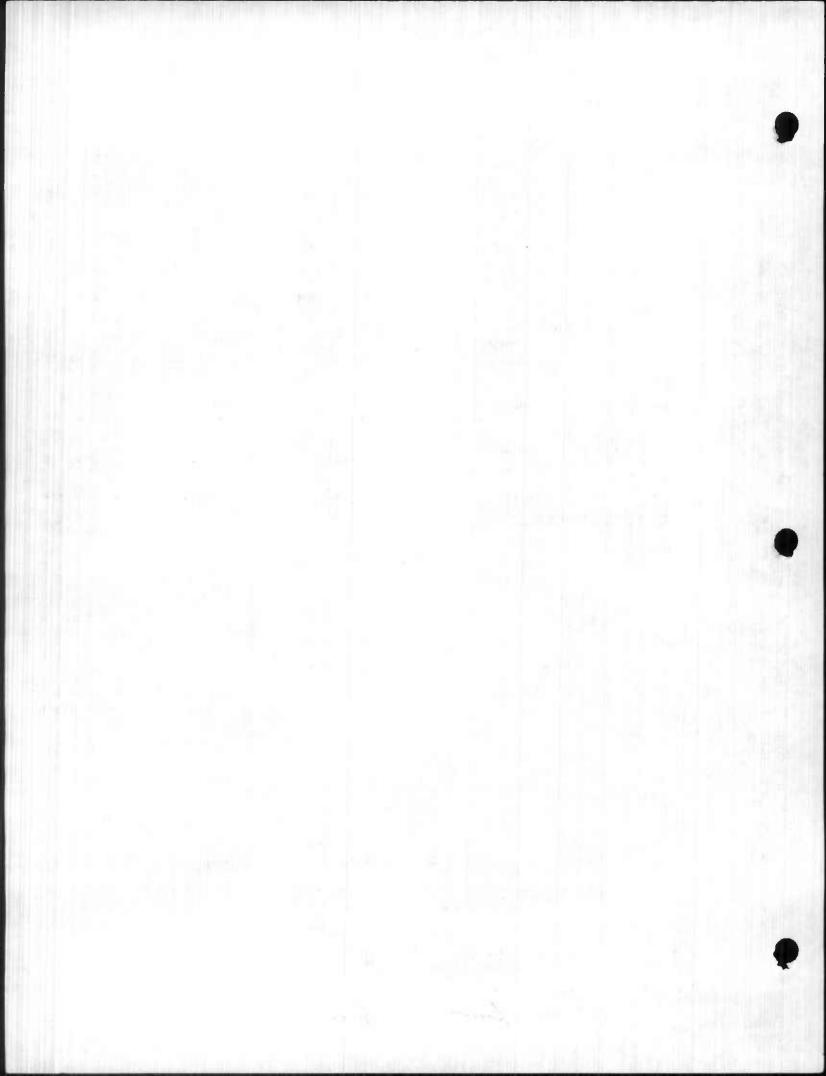
Dr. Frederic Kass, MD,

31. Data filed (Month, Day, Year) AUG 3 1 2000

Campus Road, Hagerstown, MD 21742

11110 Medical

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** Willie Bennett Little 31, 2000 0236 August /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot The Memorial Hospital Easton If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Sociel Security Number **Funeral** 10XM 20 F Days 240-56-0484 70 Yrs. Director 6.1930 North Carolina Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow traumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Caroline Preston Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23s or P.O. Box 464 21655 United States by Funeral 14. Race - American Indian, Black, While, etc. 12. Was Decedent Ever in U,S. Armed Forces? t ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 X No Specify Specify: Black 3 Nidowed 4 Divorced Il Hygiene. other than "netural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Farm Worker Farming 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) should be find Mental h and Mental Bennett Little Mary Ethel LeGrand 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Nem 27 Is meny injury or other traum pace. Albert R. Little/Son 990 Swan Lane, Ruther Glen, VA Saitimore, 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □ Removal from State 9/8/00 Mt. Gilead, N.C. Snow Hill Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Framptom-Hawkins-Eskow Funeral Home, 216 N. Main St. Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) usa as the bunai-trar The law requires that the death certificate be execu Physician/Medical Due to (or as a consequence of): Box Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? PO 1 Yaa 2 No 3 Probably 4 Unknown signed by py of Vital Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 DAY 1 ☐ Yes 1 ☐ Yes 2 ☐ No iabe soptal or Attending Physician: Thours after death.

neral Director: After this certificat
y filled in by the funeral director, p Be 25. Was case referred to medical 26. Piace of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 110 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Division 5 Pending Investigation 1 Natural 1 Tyes 2 No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 12 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar 29b. Signature and title of certifier

James 31. Date filed (Month, Dey, Year)

920 Market St. Sides 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

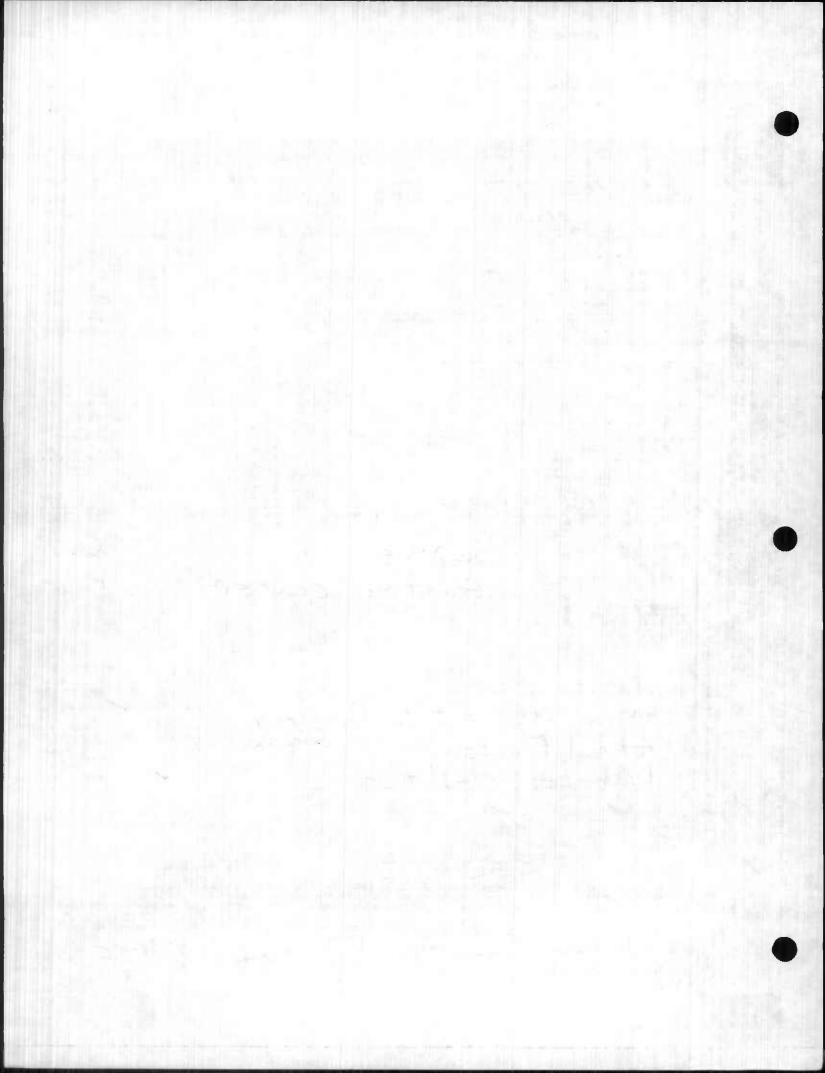
29c. License number

Denton, MD

21629

29d. Date signed (Month, Day, Year)

Little

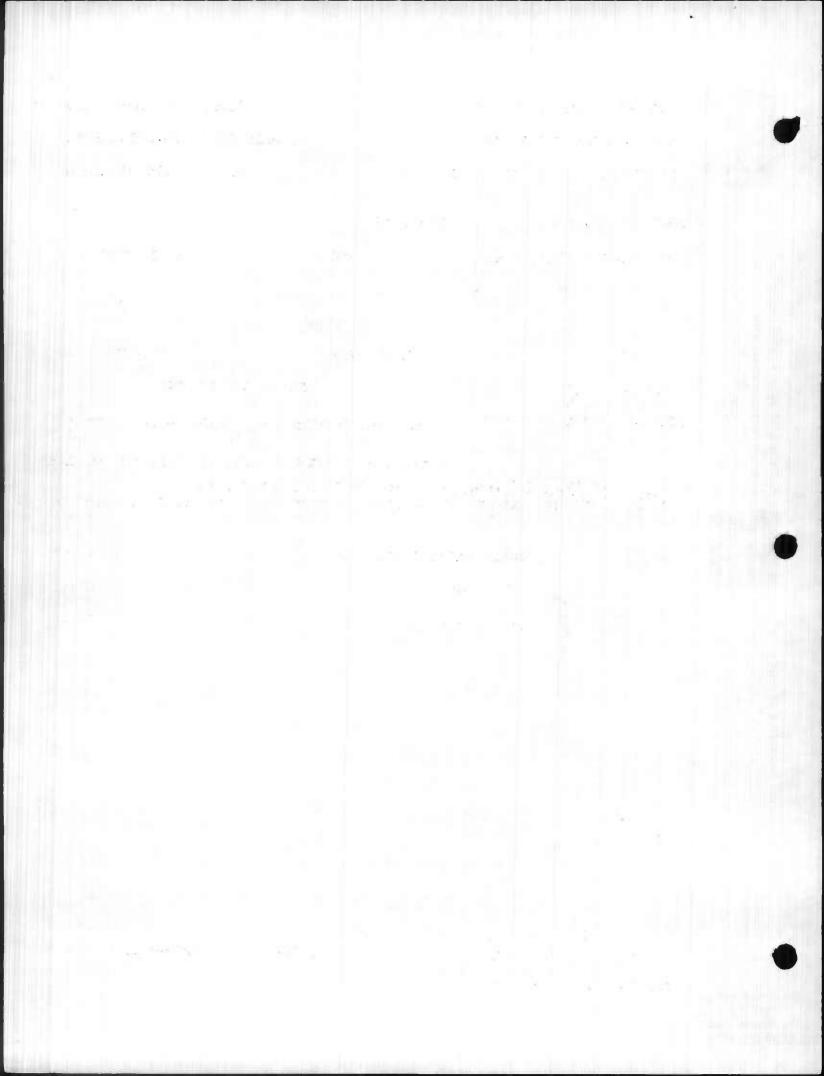


#### Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 29289

					Cei	rtificat	e of	Death			Reg. No.		7 5 0 2
		1. Decedent's Name (First, Middla, La	st)							2. Date of De		Maria	3. Time of Death
Phys		CONSTANCE CECELI	A POSEY MY	ERS						SEPT.	A, 2	000	8:30 PM
/ivie Exan	dical siner	4a Fscility Name (If not institution, giv	re street end number)					4b. City, To	own, or L	ocation of Death	4c. County	of Death	
LAUI		FORT WASHINGTON	HOSPITAL					FORT	WASH	INGTON	PRINC	E GEX	ORGES
Funer	al ·	5. Social Security Number 6. S	Sex 7. Age	e (in yrs. le	st birthday)	If Under		if Undar		8. Data of Bir	th ,	9. Birth	placa (Stete or Foreign
Directo		217-72-7622	I□M 2125F	90	Yrs.	Months	Days	Hours	Min.	FEB. 3	1910	MAR	YLAND
		Usual Residence of Decedent											
.0020 hours effer deeth with the Maryland huref, or flems 23s or 28s-f show Example mass be notified at		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
Mar	to	MARYLAND CHARLES		BRY	YANS F	ROAD							1 X Yes 2 No
the the	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Cou	ntry?
1020  Vars effer deeth with the Marylen effer deeth with the Marylen eff. or Nems 23s or 28s-1 show Examiner must be notified at		6855 RALPH D. MYE	DC DI ACE				2061	6			UNITED	פיייעיי	RS
eeth	Funeral	11. Manital Status	12. Was Decedant B	Evar in U.S.	13				igin? (So	ecify Yas or No			can Indian,
ler d	5	1 Navar Married 2 Married	Armed Forces?			f Yes, spe	cify Cub	an, Mexica	n, Puerto	Rican, etc.)		ck, White,	
21215-0020 d within 72 hours eff gjene. In them "naturel", or the maturel or the	by F	3 ₩ Widowed 4 □ Divorced	If Yas, Giva Year or Dates:	40		1 🗆 Yes	2 No	Specify	:		Specif	BI.	ACK
15-002 72 hours "naturel".		15. Decedent's E			16a Danos	donto Hau	al Occur	nation			16b. Kind of B		
15- n 72	Completed	(Specify only highest gre			16a. Dece	kind of wo	rk done	during mos	st of work	ring	TOD. KING OF B	usiliosaviii	idustry
within within then.	E	Eiementary/Secondary (0-12)	College (1-4or 5	+)				0)			LIOME	MAK	rD.
		8TH GRADE  17. Fathar's Nama (First, Middle, Last,	1		HU	TE MAI	KER	19 Moth	ode Nam	o /First Middle			Lin
be file dothe	Be									ame (First, Middle, Maiden Sumema)			
arylar should b nd Ments n marked	2	ALEXANDER POSEY								JONES POSEY			
Maryland of 2 should be file lith and Mental Hy 7 is marked oth traumatic event		19a. Informant's Name/Reletionship (		19b. Mailing Address (Street end Number or 5370 NET SON POTN'T RO									
	ment of Heam of Univ or other	LILLIE M. BROWNE	/ DAUGHTER		5370 NELSON POINT			OINT	ROAL				
Baltimore, Semit. Peges 1 a Department of Hee mportant: If Nem any Injury or othe		20a. Method of Disposition  12 Burial 2 Cremation 3	Bomovai from State	20b. Pla	Place of Disposition (Name of cometery, cremetory or other place)					Date	20c. Location	- City or T	own, State
Peg Peg Int: I		4 Donation 5 Other (Specif		LING	COLN N	MEMOR:	IAL	CEM.	ig	/11/00	SUITLA	ND,	MARYLAND
in partir		21. Signature of Funeral Service Licer	isee L O		22	. Name ar	nd Addre	ss of Facil	ity				
m aaes		mydia C. Mar	when bord	+2m						ME, P.A		242	DIT 3300 200
		IA C. THORNI 23a. Pert 1. Enter the disease, or com										, MA	RYLAND 2064 Approximate
2. 2. 2.		shock, or heart failura. List only	one cause on aach lin	10.	DO NOT BIN	or the moc	Je or ayıı	ng, such as	cardiac	or respiratory a	11001,		tnterval Between Onset and Death
Physicia /Medica	_	- The state of the										1	
Examine		Immediate Ceuse (Finel disease or condition resulting in death)	a CEREBROV	/ASCUI	LAR AC	CIDE	NT						3 DAYS
		resuming in death)		Due to (or	as a consec	quence of):						1	
sit ad	- e		HYPERTEN	NSION									YEARS
58760, icate be asscute physician and s the bunal-trans	edicai Examiner	Sequentially list conditiona,		Due to (or	as e consec	quence of):						- 1	
e axe	E	Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury	ATHEROS	CLERO	SIS								YEARS
x 68760, ertificate be asscut- ling physician and a as the bunal-tran	dica	that initiated events resulting in death) Last			es a conseq	uence of):						1	
2 0 6	Mec												
Box 6  Both certiff attanding	an		d									1	
. 0 00	Physician	Pert It. Other significant conditions of	ontributing to death bu	ut not result	ting in the u	nderlying o	ause giv	ven in Part	i.	23b. Dld	tobacco use co	ntribute t	to the cause of death?
P.O. at the at the etache	hy									10	Yes 2XXNo	3 🗌 Pro	bably 4 Unknown
	by F												
ords requiras een sign hould be											an autopsy	24b. W	/ere autopsy findings
COrd v requir been s should	ete									pend	ormed?	C	vailable prior to ompletion of cause I death?
Record ne law require s hes been si	Completed												
= F # d										10	Yes 2 No	1	☐ Yas 2☐ No
Of Vital Physician: T this certifical ral director, p	Be	25. Was case referred to medical examiner?	Magnital.				10"		e of Deal	th (Check only	one)		
Physic this c	To	1 ☐ Yes 2 ◯ No	Hospital:		R/Outpatier		JA		ursing Ho		denca 6 □Ott		ify)
	Ë	27. Menner of Deeth 1 XNatural 5 ☐ Pending	28a. Date of Injur (Month, Dey	Year) 2	28b. Time of Injury	1 2	28c. Injui Wo	ry at rk?		28d. Describe	how injury occur	rred	
VISION Attending or death. Ector: After by the fune	atie	2 Accidant invastigation				M	1 🗆	Yes 2	No				
	tific	3 Suicide 6 Could not b	e 28e. Piace of Injubuilding, etc			eet, factor	y, office			28f. Location ( City or To	Street and Numi	ber or Aur	ral Route Number,
Div s after al Direct	Certification:		bunding, ord	. (Opochy)							,,		
Dir To the Hospital or within 24 hours after To the Funeral Dir completaly filled in													
e Ho	edicai	(Check only 2 Medical Exam	ng Physician: To the best of my knowledge, deeth occurred at the time, date and piace, and due to the causa(s) and menner as stated.  Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the canding menner stated.						to the cause(s)				
vithir of th	Ž	29b. Signature and title of certifier	0			290	c. Licens	se number			29d. Data signe	d (Month,	, Day, Year)
F > F 0		1-1-1	1			-	2200	00 /3/	2)		CE-Denies (ID)	ם מיב	2000
	- 4	9Class	unglos				3280	M) 00	) <u>)</u>	] ;	SEPTEMBI	C 7L	2000
		30. Name and address of person who		eath (Item 2	23а) (Туре,	Print)							
		HILARY H. WASHING		ula Cimera									
	itate	31. Date filed (Month, Dev. Yeer) SEP 0 6 2	32. Registra	ars Signatu	La La	14	1						
Regis	olrdi	OLI 0 0 2	.000		1	19	OPEN	62/					

DHMH 16 Rev 6/95



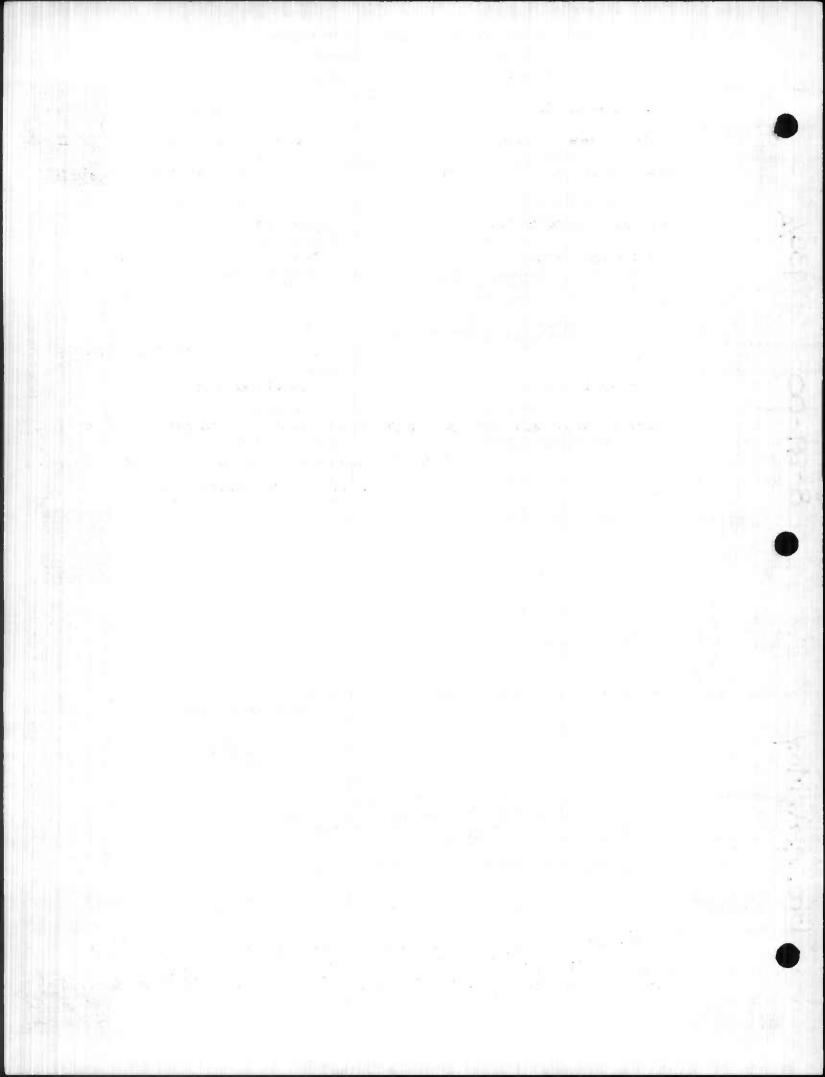
### Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

partment of Health and M	fental Hygiene	00	2	9	2	9	1
ertificate of Death	Reg. No.		finns	1	Louis	1	(

COLUMN TO SERVICE		Decedent's Neme (First, Middle, La.	st)		08	rtificate	01	Dealli		Date of Deet	eg. No.	3	3. Time of Death	
Physiciar /Medica	_	GRACE ALBERTA MA	ΔY						5	Month August	29, 20	000	9:35 AM	
Examine		4a. Facility Name (If not institution, give Homewood Nursing		er)					own, or Local	ion of Death	4c. County	of Death	ounty	
Funeral Director		5. Social Security Number 6. S 215-64-2393	ex 7. □м 2/Ω F	Age (In yrs. le 91	est birthdey) Yrs.	If Under Months		If Under Hours	24 Hrs. 8. Min. No	Dete of Birth (Month, Day, OV • 30	Year) 908	9. Birthpiac Country Mary	e (State or Foreign	
2 -	-	Usual Residence of Decedent		10.00										
ath with the Maryan 123e or 28a-f show mat be notified at	ctor	Maryland Washing	on Co.	10c. City	, Town or Lo	cation	На	agerst	cown			10d.	Inside City Limits 1 XYes 2 No	
23s or 2 ast be no	al Director	10e. Street and Number 1113 Glenwood Ave	enue			10f. Zlp	Code	21742	2	16	0g. Citizen of	What Country' USA	7	
af, or items Examiner of	by Funeral	11. Merital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Dete	as? Ano		Was Deced If Yes, spec		dispanic Ori en, Mexical Specify:		y Yes or No- an, etc.)	Bla	ce-American ck, Whita, etc. y: White		
han 'natur e Medical	Completed	15. Decedant's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4d	or 5+)					st of working		16b. Kind of B		npany	
lory or other traumatic even	17. Father's Name (First, Middla, Last)	Vice President Electr  16. Mother's Name (First, Middle, Malden Suma								Maiden Suman		ipary		
	Charles Frederick		S						lberta					
	19a. Informant's Name/Raiationship ( Annette L. Dahlha  20a. Method of Disposition  1	mer, Dau	20b. Pl	166 aca of Dispo	13 Tan	nmar. le of ther pla	ny Lar	ne, Wi	lliams	20c. Location	Marylan - City or Town	d 21795 , Stete		
	4 Donation 5 Other (Specify	1)	Re	st Ha			-		pt. 1		stown,	Maryland		
amy i		21. Signature of Funeral Service Licen	960							uneral			and 2174	
ysician Medical aminer	niner	uner.	Part1. Enter the disaasa, or comshock, or hear Hallure. List only  Immediate Causa (Final disease or condition resulting in death)	olications that causona cause on aach	C	ACHU	KIA	of dyir	ng, such as	cardlac or re	espiratory arre	est,	Int	peroximate serval Between neet and Death
iel-transit		•	b/V	UTE	4774	5						12-	SWEEK	
bur bur		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	c. Gul	O Str	es a consec es e consec	Acre	4CA	MEN	\$ 7.	) EME	MA	2	YCAN	
	2	resulting In deeth) Last	d	50010101	00 0011000	ontou ory.						1		
etached for use a	SICI	Part II. Other algolificant conditions of	ontributing to death	h but not resy	ting In the u	nderlying ca	use giv	ven in Part I	1.	23b. Dld to	bacco use co	entributa to th	e cause of death?	
80		HIP FRAG	etuals	8/0	1/00	PAY	#0,	100/0	AL.	1 🗆 Ye	08 2 NO	3 Probab	dy 4 Unknow	
2 20	2	Completed by							24a. Was as perform		availa	autopsy findings ble prior to letion of cause ath?		
page 2										1 □ Ye	s 2 No	1 🗆 Y	es 2 No	
ertific Sctor	0	25. Was case referred to medical examiner? 26. Plan								Check only on	-			
1 P	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Noursing Home 5													
of in by the funeral	Callor	27. Manner of Death Natural 5 Pending 2 Accident investigation		Dey Year)	28b. Time o Injury	M	Bc. Injur Wor 1 []	rk?  Yes 2 🗆		i. Describe no	ow Injury occur	med		
Director: Af		3 Sulcide 6 Could not be determined	288. PIECE OF	Injury - At hor etc. (Specify)	ne, ferm, str	eet, fectory	, office		28f	Location (St. City or Town	reet and Numi n, Stete)	ber or Rural R	oute Number,	
Plumer Fumer stery till		29a. Certifier (Check only one)	ysician: To the be- liner: On the besis and manner	of examination	ledga, daati on and/or in	occurred a	t the tir	me, date an opinion, dea	nd place, and ath occurred	due to the ca at the time, da	ause(s) and mate and piaca,	annar as stata and due to the	ed. e cause(s)	
within 2 To the comple		29b. Signature and title of Laffitier	1	2		200	Licens	se number		9	9d. Date signe	of Bloom Plan	Vanel .	

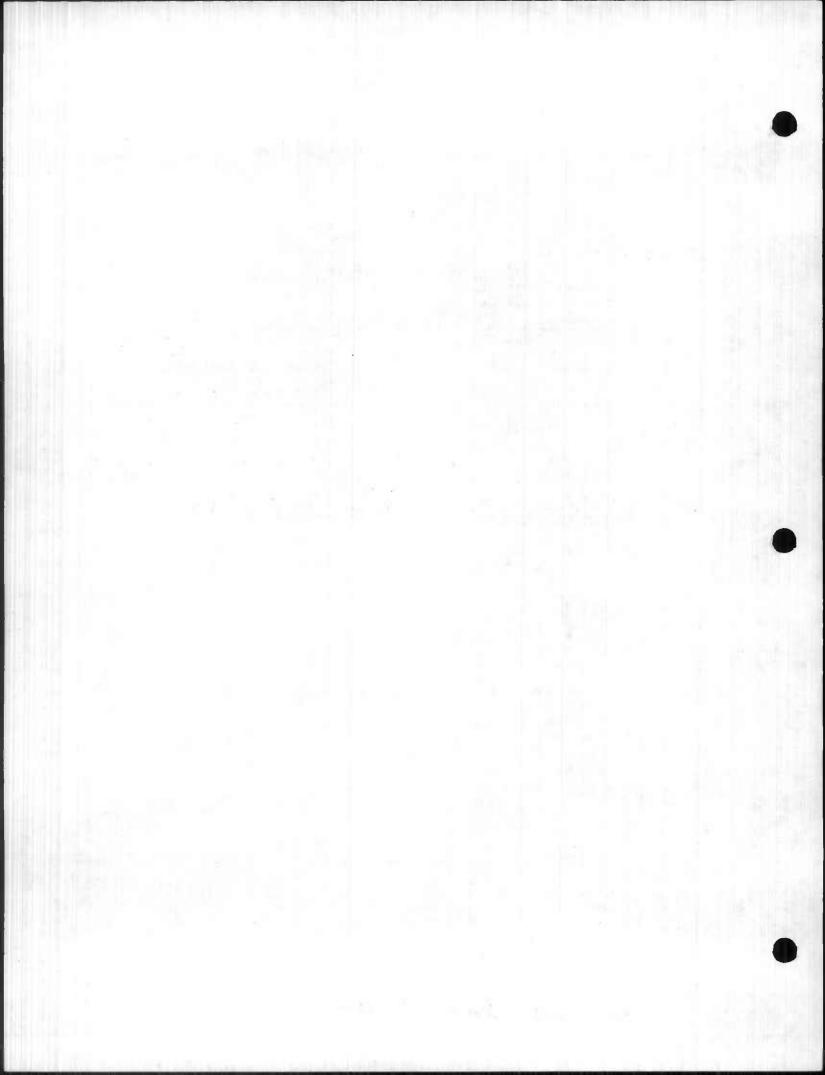
32. Registrar's Signature

State Registrar



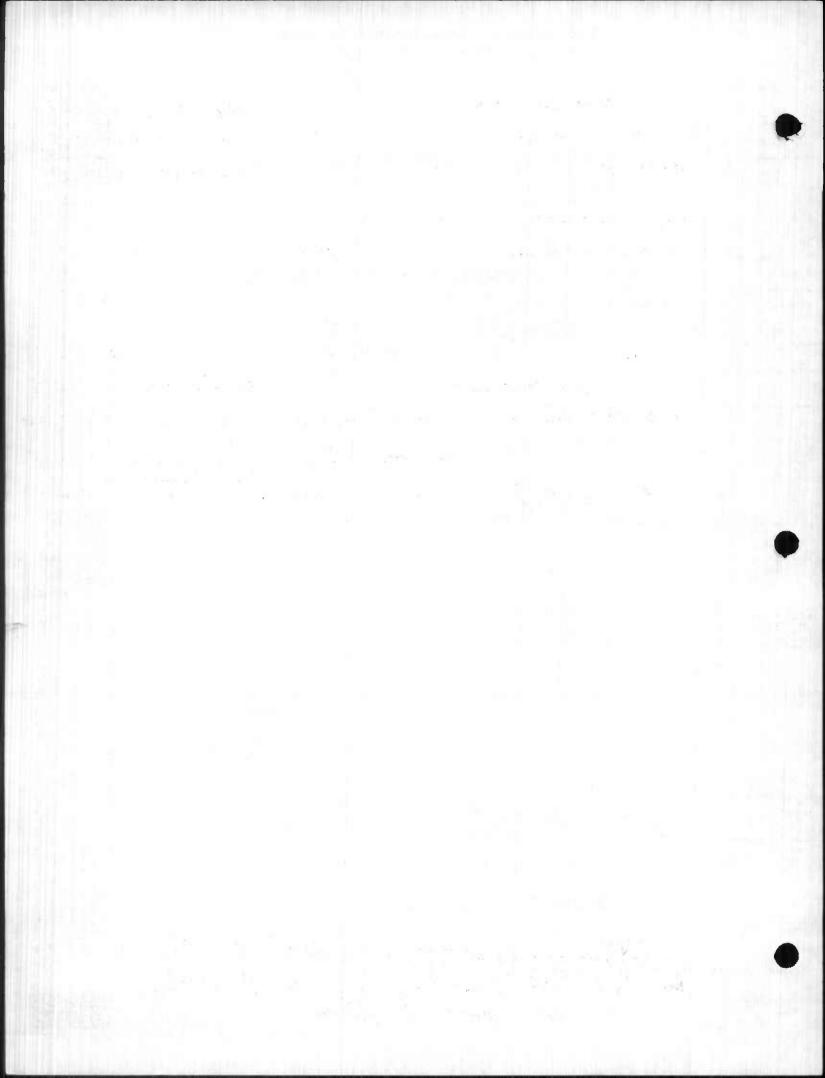
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Physician				00.		Death		Reg. No.		
Physician	1. Decedent's Name (First, Middle	e, Last)				Target and the	2. Date of			3. Tima of Death
	Emmo	Correll	Marlel				Month	Day 1 2	2000	12.05
/Medical	4a Facility Name (If not institution					4b. City, Town, or	Sept Location of De		ounty of Deat	12:05a
Examiner		r Road	.,			Knoxvi				
					If Under 1 Year	A STATE OF THE PARTY OF THE PAR			shing	
Funeral	5. Social Security Number	6. Sex 1	. Age (In yrs. I	Yrs.	Months Days		(Month,	Birth Day, Year)		hplace (State or Fore
Director	211-20-8968		74	YIS.			Sept.	10, 1925	Pen	nsylvania
	Usual Residence of Decedent  10a, State  10b, County		140- 0%	Your sale						
of H				, Town or Lo Knoxvi						10d. Inside City Lim
of the	Maryland Wash	hington		KIJOXVI	rtte					1 Yes 2X
be notified Director	10e. Street and Number				10f. Zip Code			10g. Citizer	n of What Co	ountry?
aga de	2138 Boteler	Road			2	1758			USA	
or items 23a or 28a-f shorminer must be notified at r Funeral Director	11. Marital Status	12. Was Dece	dent Ever in U.	S. 13. V	Was Decedent of	Hispanic Origin? (S	pecify Yes or	No- 14.	Rece - Ame	
Tage II	1 Never Married 2 Marr	Armed For				oan, Mexican, Puerl	o Rican, etc.)		Black, Whit	e, etc.
by F	3 ☐ Widowed 4 ♥ Divorced	If Yes, Give		1	1 ☐ Yes 2 🔯 No	Specify:		Sp	pecify:	White
	15. Deceden		1	16a Deced	dent's Usual Occu	nation		16h Kind	of Businass/	
ygens. Nr. the Medical. Completed		st grade completed)		(Give	kind of work done	during most of world)	king			
A PER	Elementary/Secondary (0-12)	College (1-	4or 5+)		et Worl			_	it Bapt	ist Conferen
C 445	17 February Name (First Middle)	( and)		DUII	er worl	18. Mother's Nar	an /Final Adiab	Center		
Be see	17. Father's Nama (First, Middle,								a19/	
Men Ne	John J. J. I			1		Rosa J				
and and	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	ng Address (Stree	t and Number or Ru	iral Route Nur	nber, City or T	own, State, 2	Zip Coda)
1 27 W	Robert R. Ma	rkle	Son	P. 0	Box 2	01 Keed	ysvil:	le, Ma	ryla	nd 21756
1 1 1	20a. Method of Disposition			ace of Dispos	sition (Name of natory or other ple		Date		tion - City or	
E 10 6	1 Burial 2X Cremation 4 Donation 5 Other (S		tate				0/2/0	O Cmi+	hahu	rg, Mary
	21. Signature of Funeral Service		3111.		. Name and Addre		3/2/0	OBILL	.nsbu.	ig, mary
DO THE	21. Signature of Potential Service	) Ma				Minnich	305	N. Pot	omoo S	troot
2260	VIIIVA 1	INN	mic							
	23s. Part1. Enter the disease, or	complications that co	used the death	Flo not ente	uneral H	ome	Hage	rstown	, Mary	Land ZI/
	shock, or heart failure. List	only one cause on ea	ch line.	DO NOT OTHE	ar the most of dy	ing, soon as cardial	or respiretory	uriost,		Interval Between Onset and Death
ysician										Onset and Death
Medical aminer	Immediata Causa (Final disease or condition		B	rast	Conce					Gyears
100	resulting in death)	<b>a</b> .	Due to (or	as a conseq	juence of):					
- E										
Par E	Sequentially list conditions	В.	Due to (or	as a conseq	luence of):					
EX E	if any, leading to immediate cause. Enter Underlying									
physician and its the bunal-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	С	Due to for		uanaa eft:					
25 -	resulting in death) Last		Due to (or	as a consequ	uence or):					
2 B		d								
ig : ₹										
ig : ₹										
ig : ₹	Part II. Other significant condition	ens contributing to dea	th but not resu	Iting in the ur	nderlying cause gi	ven in Part I.	23b. D	id tobacco us	a contribute	a to the cause of de
by the attending tached for use a hysiclan/M	Part II. Other significant condition	ons contributing to dea	th but not resu	Iting in the ur	nderlying cause gi	ven in Part I.		id tobacco us	-	
d by the attending stached for use a Physiclan/M	Part II. Other significant condition	ons contributing to dea	ith but not resu	lting in the ur	nderlying cause gi	ven in Part I.			-	
gned by the attending be detached for use a by Physician/M	Part II. Other significant condition	ns contributing to dea	ith but not resu	iting in the ur	nderlying cause gi	ven in Part I.	1 24a. W	Yea 22	No 3□P	robably 4 Unkr
gned by the attending be detached for use a by Physician/M	Part II. Other significant condition	ns contributing to dea	th but not resu	lting in the ur	nderlying cause gi	ven in Part I.	1 24a. W	□ Yea 2 2 3	No 3□P	robably 4 Unkn Were autopsy finding evailable prior to completion of cause
gned by the attending be detached for use a by Physician/M	Part II. Other significant condition	vns contributing to dea	th but not resu	iting in the ur	nderlying cause gi	ven in Part I.	1 24a. W	Yea 22	No 3□P	robably 4 Unkr
ate has been signed by the attending page 2 should be detached for use a completed by Physician/M	Part II. Other significant condition	vns contributing to dea	ith but not resu	iting in the ur	nderlying cause gi	ven in Part I.	24a. W	Yea 22	No 3□P	robably 4 Unkn Were autopsy finding evailable prior to completion of cause
ate has been signed by the attending page 2 should be detached for use a completed by Physician/M	25. Was case referred to medical		th but not resu	iting in the ur	nderlying cause gi	ven in Part I.  26. Placa of De.	24a. W	as an autopsy rformed?	No 3□P	were autopsy findin evailable prior to completion of cause of death?
s certificate has been signed by the attending director, page 2 should be detached for use a for Be Completed by Physician/M		Hospital-		Iting in the un	100		24a. W pe	as an autopsy formed?	No 3□P 24b.	Were autopsy finding evailable prior to completion of cause of death?
this certificate has been signed by the attending all director, page 2 should be detached for use a sign of the si	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ In	patient 2 □ (	ER/Outpatien 28b. Tima of	nt 3□ DOA O	26. Placa of Der her: 4 □ Nursing H	24a. W pe	as an autopsy formed?	No 3 P	were autopsy findine evailable prior to completion of cause of death?
this certificate has been signed by the attending all director, page 2 should be detached for use a sign of the si	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin	Hospital: 1 In In 28a. Date of (Month)	patient 2□(	ER/Outpatien	at 3 DOA Ot	26. Placa of Der her: 4 □ Nursing H	24a. W pe	as an autopsynformed?  Yes 2 1/1  Yes 2 1/1  yona)  asidence 6 [	No 3 P	Were autopsy finding evailable prior to completion of cause of death?
this certificate has been signed by the attending all director, page 2 should be detached for use a sign of the si	25. Was case referred to medical examiner?  1  Yes 2  No  27. Manner of Death 1  Natural 5  Pendin investig 3  Suicide 6  Could re	Hospital: 1 In Ing	patient 2 liquy	ER/Outpatien 28b. Tima of Injury	at 3 DOA Of 28c. Inju	26. Placa of De. her: 4□ Nursing H	24a. W pe	as an autopsynformed?  Yes 2 1/2 4/2 ona)  asidence 6 [  be how injury of	No 3 P	robably 4 Unkn Were autopsy finding evailable prior to completion of cause of death?  1 Yes 2 No
this certificate has been signed by the attending all director, page 2 should be detached for use a sign of the si	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	Hospital: 1 In Ing	patient 2 liquy	ER/Outpatien 28b. Tima of Injury me, farm, str	at 3 DOA Ot	26. Placa of De. her: 4□ Nursing H	24a. W per state of the control of t	as an autopsynformed?  Yes 2 1/2 4/2 ona)  asidence 6 [  be how injury of	No 3 P	were autopsy findine evailable prior to completion of cause of death?
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					Ce	rtificate	e of	Death			Reg. No.		
Physicia	an	1. Decedant's Nama (First, Middla,	Last) Olive MC	cc						2. Data of De Month		Year	3. Time of Death
/Medic Examin	al	4a. Facility Nama (If not institution, 16505 Virginia	giva street and numb				_			ocation of Death		y of Death	8:00 A
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-f show	tor	10a. Stata 10b. County Maryland Washing	gton		Town or Lo			7. 7				1	0d. Inside City Lin
3a or 28a pt be not	Funeral Director	10e. Street and Number 16505 Virginia	Avenue			10f. Zlp		21795		T	10g. Citizen of U.S		try?
*natural", or flems 23a or 28a-f show solical Examinet must be notified at	by	11. Marital Status  1 Navar Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decede Armed Force d 1  Yas 2 If Yas, Giva Yaar or Date	as? ⊠ No	1	Was Deced If Yas, spec	ify Cut	an, Maxicar	, Puarto	ecify Yas or No Rican, atc.)		ce - Amaric ack, Whita, fy: Wh	
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Department of Haalth and Mental Hygiene. Important: if Item 27 is marked other than any Injury or other traumatic event, the Ma ODCS.		20a, Mathod of Disposition  1  Burial 2  Cramation 3  4  Donation 5  Other (Spe  21. Signature of Fundal Service Li	ecify)	cen	t Hav		net d Addr	ery ass of Facilit	by N	Data Sept. 6,2000 Minnich	Funera	town,	Marylar
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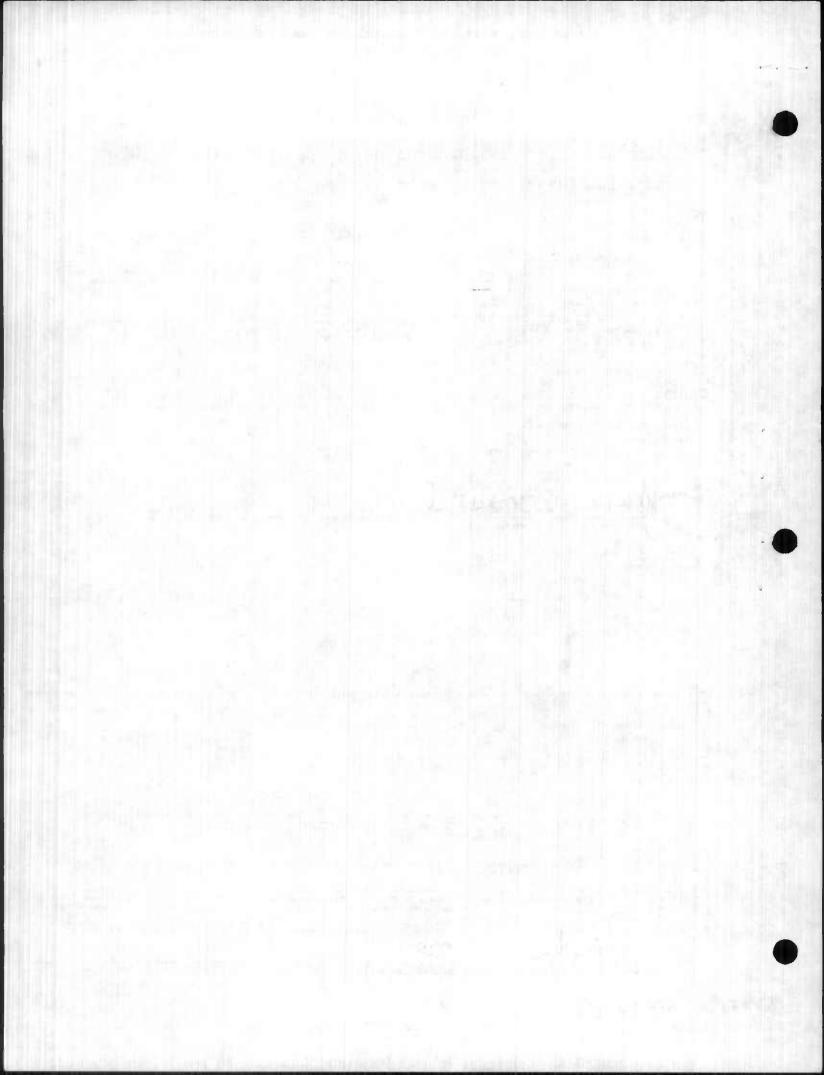


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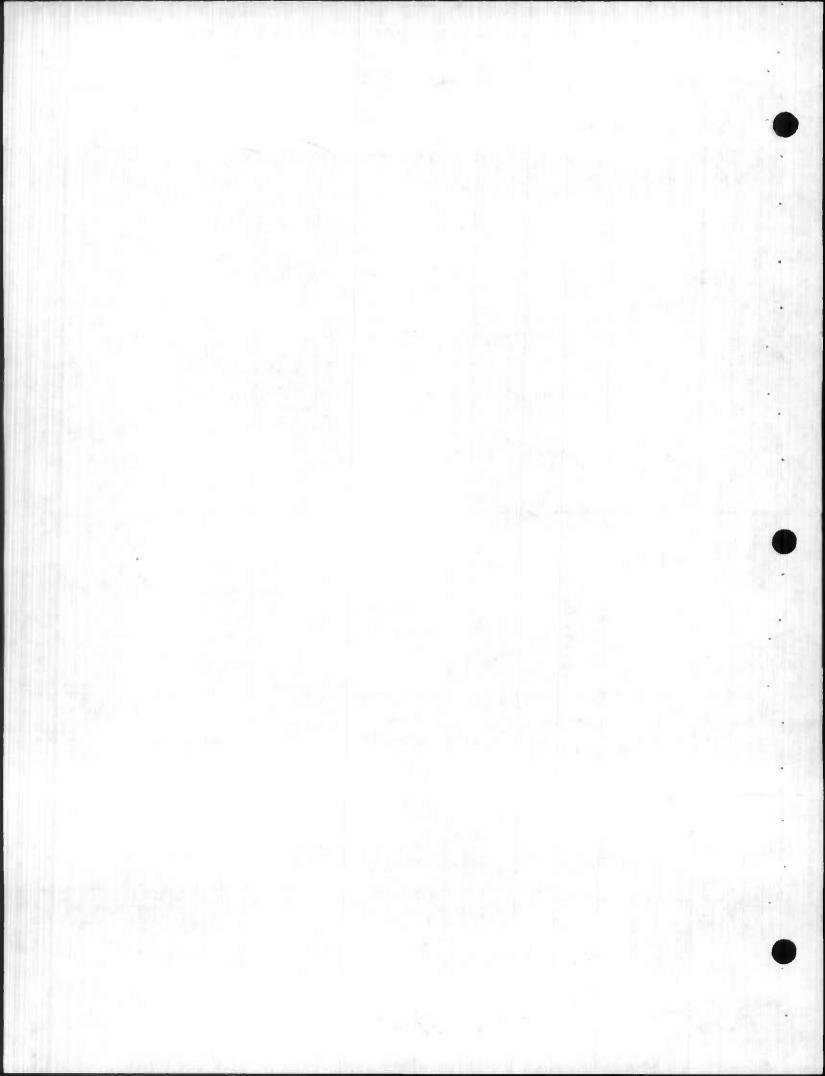
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State Registrar



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		1 63 5	10e. Street and No. 750 Dual					10f. Zip C 2174					citizen of Who		
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	Balt	Departi Departi Imports any inj ance	21. Signature of F	uneral Service Licer	Mad-	•				ss of Facility M					17055
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		To the within 7 To the comple	29b. Signature an	d tyle of certifier		A		29c.	Licens	se number		29d.	Date signed	(Month, E	Day, Year)
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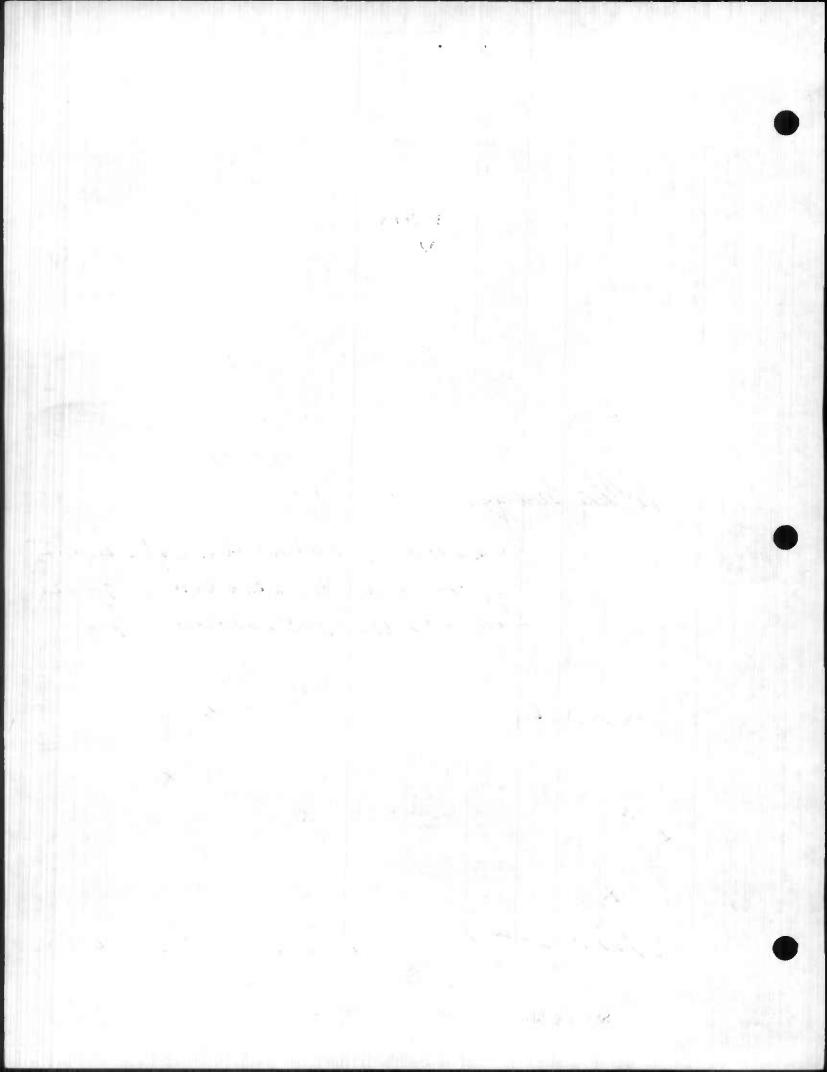


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State of Maryland / Department of Health and Mental Hygiene 00 29295

				Certifica	te of	Death		Re	g. No.	, ,	5230	
Hall will	1. Decedent's Neme (First, Middle, L	ast)						te of Deeth	Day	Year	3. Time of Death	
Physician /Medical	JAMES ALBERT	NAHM						pt. 4		1 oai	4:15AM	
Examiner	4a Facility Neme (# not Institution, g	ive street and number)				4b. City, Town			4c. County	of Deeth	-	
9-11	Berlin Nursing	Rehabilita	tion Ce	nter		Berlin			Worce	ster		
Funeral Director	212 07 7964	Sex 7. Age 12 F 9	(In yrs. last birtl	nday) If Under Months	Days		Min. (Mi	te of Birth onth, Dey, ne 16	Year) , 1910	9. Birthp Coun Mary	lace (Stete or Foreign try) yland	
ahow	Usuel Residence of Decedent  10a. State 10b. County  MD Baltimo	re City	10c. City, Town							1	0d. Inside City Limits	
atter death with the Menylend at terms 23e or 28e-f show miner must be notified at Funeral Director	10e. Street and Number			10f. Z	p Code				g. Citizen of V	Vhel Coun		
ath vath	301 Taplow Road		out a LLC		212	Hispania Osiala	2 (5		J.S.A.	e - Americ	eo lodico	
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1 21215-0020 ed within 72 hours af ed within 72 hours af ygjene. Ser than "natural", or fr, the Medical Evern Completed by F	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or 5-	+)	life. DO NOT	ork done use retire	during most o	working	1	6b. Kind of Bu	usiness/Inc	dustry	
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T VICAI ME yeldan: The law is certificate has director, page 2	25. Wes case referred to medical					26. Place o	Death (Che	ck only one	)			
T the side T	1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Oulpatient 3 DOA						28d. D	ng Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred			(y)	
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To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert	29e. Certifier (Check only one)  Certifying F	ime, dete end popinion, deeth	placa, end du occurred at II	e to the ce he time, da	use(s) and me te and plece,	enner as s and due lo	tated. o the cause(s)					
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	30. Name and address of person who	o completed called of do	eth (Item 23e) (T	(vne Print)	00	204	0	_	Sup (	1-	2000	
5	DR. FEDERICO	ARTHES 9	715 Hea		Dr.	Berlin	, MD	218	11			
State Registrar	31. Dete filed (Month, Dey, Year)		r's Signeture	6.	doa	Ks/						

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 29296 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4115 PM September 3 Wilburn George Osborne, Sr. 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 10803 Roessner Avenue Hagerstown Washington Birthplace (State or Foreign Country) H Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 11XM 2□ F Months Yrs. Director 235-32-2105 74 West Virginia May 1, 1926 Usual Residence of Decedent 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits 1 Yes 200 No Director 280-1 Maryland Washington Hagerstown 10e. Street and Number 101. Zip Code 10g. Citizen of What Country? ð Nerns 23s 10803 Roessner Avenue 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No HYes, Give Year or Dates: 105 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married permit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mantal Hygiens. Preferred: if Preportent: if them 27 is marked other than "netured", or any injury or other traumstic event, the Medical Exami 1943-Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced White 1950 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Equipment Manufacturer 10 Assembler 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Robert Dewey Osborne Lura Clyde Robbins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bill Osborne, Jr./Son 11339 Rock Hill Rd. Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Dogatton 5 Other (Specify) 9-7-00 Williamsport, Maryland Greenlawn Mem. Park 21. Signifure of Funeral Service Licent OSBOTTE ATTHEFET Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of): The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical physic the t Due to (or as a consequence of): signed by the a Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings svaliable prior to completion of ceuse of death? 24e. Was an autopsy performed? 1□ Yes 2BNo 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4□ Nursing Home 5 Residence 6 □Other (Specify) 1 Yes 2 No Medical Certification: To this funeral 27. Manney of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural e Hospital or Attending n 24 hours after death. e Funeral Director: Afte 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or Investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2 To the I To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) michael &. Mulanul MD 9.6.00 041667

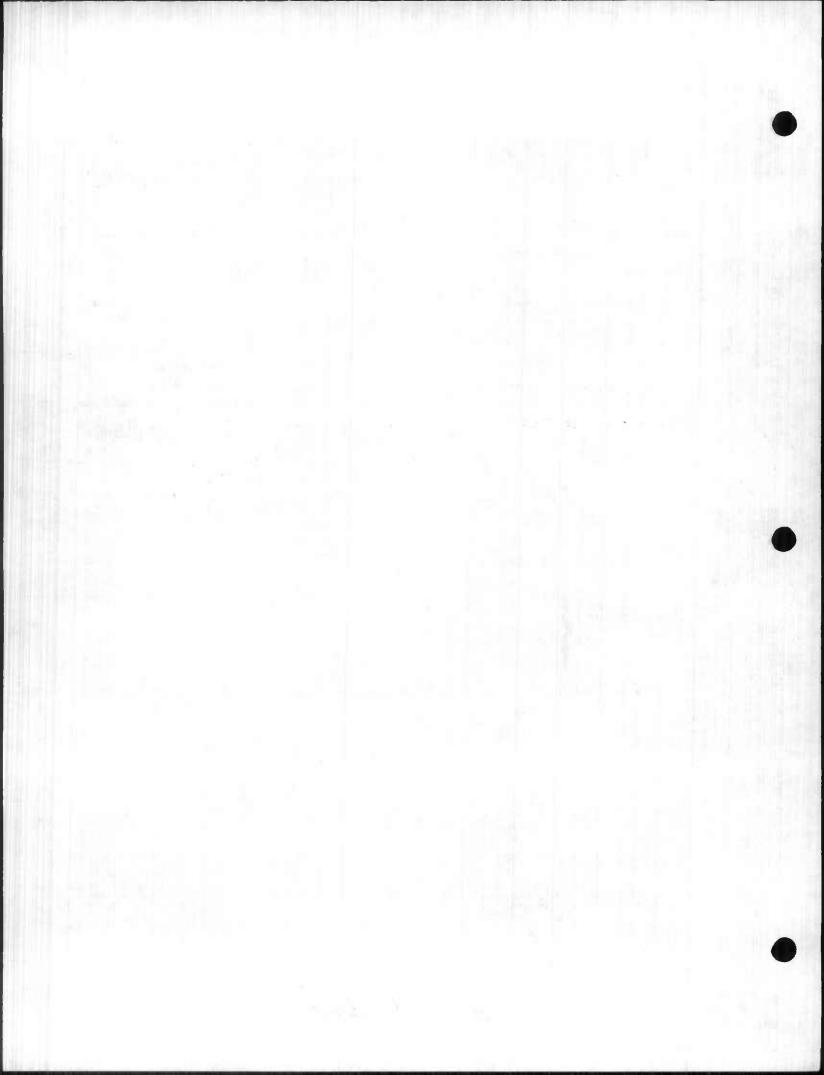
State Registrar

31. Date filed (Month, Day, Year) SEP 0 6 2000

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

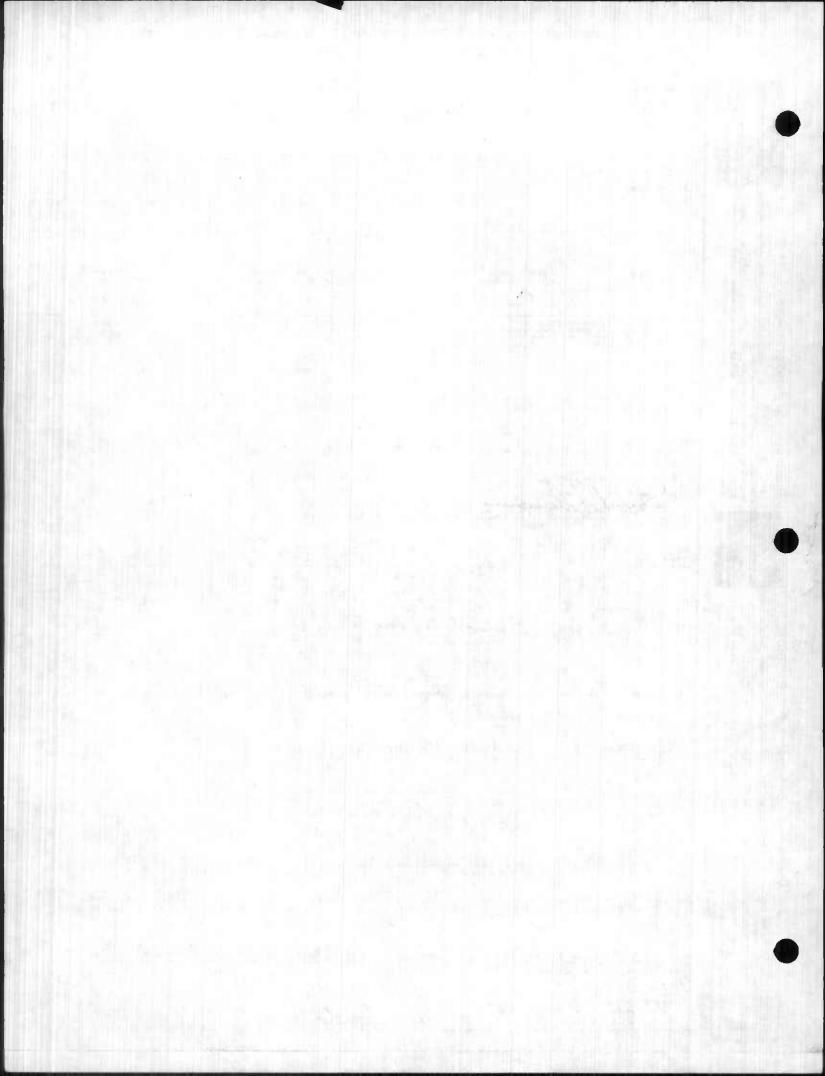
Michael McCorneole 32. Registrar's Signature

Capper Hegers Nowa MP 21742 11110 Medical



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	Certificate of Death		Reg. No.			
hysician	1. Decedent's Nama (First, Middle, Last)	2. Data of Dea Month	ath Day Yes	3. Time of Death		
/Medical	Edmund I. Cakes &	Hugu.	st 29 20	200 01:40 pm		
xaminer	4a Facility Neme (If not Institution, give street end number)  4b. City, Town	n, or Location of Beeth	4c. County of De	eeth		
	SHADY GROVE ADVENTIST HOSPITAL ROCKY	VILLE	MONTGOM	1ERY		
eral	5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours	4 Hrs. 8. Date of Birt (Month, De	h Year) 9. F	Birthplace (State or Foraign Country)		
ctor	578-76-2654 1XDM 2 F 80 Yrs. Months Days Hours	Sept 2		Pennsylvania		
-	Usual Residence of Decedent					
	10a. Stete 10b. County 10c. City, Town or Location			10d. fnside City Limits		
to	Maryland Montgomery Rockville			Yes 2 No		
Directo	10e. Street and Number 10f. Zip Code		10g. Citizen of What	Country?		
	9503 Veirs Drive #2 20850	100	United S	States		
Funeral	7500	in? (Specify Yaa or No-		mericen Indian,		
5	11. Marital Stetus  12. Was Decedent Ever in U,S. Armed Forces?  1 Never Merried 2 Married  12. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Very Company C	Puarto Ricen, etc.)	Black, W	/hite, etc.		
by F	3 □ Widowed 4 □ Divorced Year or Datas: WWII 1□ Yes 2♥ No Specify:		Specify: W	Vhite		
	15. Decedent's Education 16a. Decedent's Usual Occupetion		16b. Kind of Busine	es/Industry		
Completed	(Specify only highest grade completed)  (Giva kind of work done during most of life. DO NOT use retired)	of working	100.11.110 0. 200110	our roomy		
E G	Elementery/Secondary (0-12) College (1-4or 5+)		Fodowol.	Government		
	2. Bank Examiner  17. Father's Name (First, Middle, Last) 18. Mother's	e Namo /Firet Middle		Government		
Be	[10] [2] [2] [2] [2] [2] [2] [2] [2] [2] [2		me (First, Middle, Meiden Surneme) ret Keating			
2			ret Keating  Aural Route Number, City or Town, State, Zip Code)			
o Amil	Anne A. Oakes/ Wife 9503 Veirs Dr., #	2, Rockvil				
	20a. Method of Disposition (Neme of cematery, cremetory or other pleca)	Aug. 30,	20c. Location - City	or Town, State		
	1 □ Burial 2 ▼ Cremation 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify)  Chesapeake Crematory Inc	. 8000	Beltsvil	lle,Maryland		
	21. Signalure of Funeral Service Licenses 22. Nama and Address of Facility					
	Rapp Funeral an	nd Cremati	on Service	25		
	933 Gist Ave.,			Approximate		
-	23e. Part1. Enfer the disease, or complications that coused the deeth. Do not enter the mode of dying, such as conshock, or heart failure. List only one cause on each line.	arolas or rospiratory at	1001,	Interval Between Onset and Deeth		
an al	Immediate Cause /Final			1		
er	Immediate Ceuse (Finel disease or condition resulting in deeth)  Respiratory failure  Due to (or as a consequence of):	e	-1-2-1-2-2-3	Ininute		
	Due to (or as a consequence of):	Q 1				
in a	b. Total Orgian System +	ailure		15 days		
Examiner	Sequentially list conditions,  Due to (or es a consequence of):	Forms 2		101		
	Sequentially list conditions, if any, leeding to immediate ceuse. Enter Undartying Cause (Disease or Injury c. Bowel Ischemia			14 days		
edical Examir	that initiated events resulting in death) Last Dua to (or as a consequence of):					
5						
Sup	d					
C	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part f.	23b. Dld	tobacco use contrib	outs to the cause of death?		
thys	Chronic Atrial Fibrillation			Probably 4 Unknown		
d by Physician/						
Completed by Physician/	Chronic Obstrative Pulmanory Disea	24e. Was		tb. Ware eutopsy findings		
ete	Crironic USSTricture Julmanory Visea	perlo	ormed?	evailable prior to completion of ceuse of death?		
o Be Completed						
S		10	Yes 2 No	1 Yas 2 No		
Be	eyaminer?	of Death (Check only o	one)			
2	Hospital: P.	sing Home 5 🗆 Resi	dence 6 Other (5	Specify)		
	27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Tima of Unique Work? 28c. Injury at Work?	28d. Describe	how injury occurred			
atio	1) Natural 5 Panding (Month, Dey Year) Injury Work? 2 Accident Investigation M 1 Yes 2 N	lo				
100	3 Suicida 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office	28f. Location (	Street end Number o	r Rural Route Number,		
Certification:	4 ☐ Homicide building, etc. (Specify)	City or To	wn, State)			
0	29e. Certifier 15. Certifying Physician: To the best of my knowledge, death occurred at the time, dete and	plece, and due to the	cause(s) end menne	or as stated.		
edicai	(Check only one)  2 Medical Examiner: To the basis of examination and/or investigation, in my opinion, death one)					
2	29b. Signature and the of compler 29c. License number		29d. Date signed (M	fonth, Dev. Year)		
		III III III				
3	D18658		Hugust	29,2000		
	30. Name and addrass of person who completed ceuse of death (Item 23a) (Type, Print)	サントア	11:11 1	MD 9 MEG		
	Cary D. Brown 9715 Medical Center Drive	313, Ko	ockulle 1	117 408>8		
State	31. Date filed (Month, Dey, Year) 32. Registrar's Signeture					



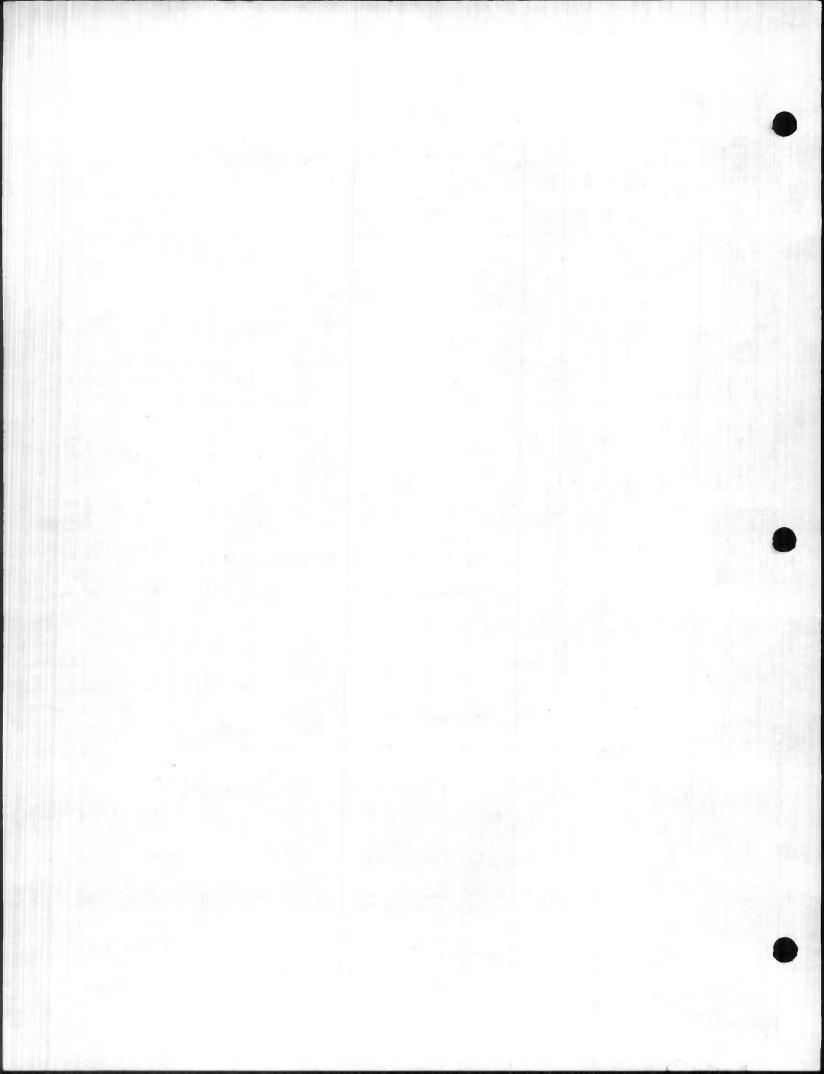
#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene | 1 Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Date of Death 3. Time of Death Month **Physician** WARREN EUGENE PARRY 29, 2000 AUG. Pr /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1071 BALTIMORE BLVD. WESTMINSTER CARROLL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3 / 4 / 1 9 2 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours **№** M 2□ F Yrs. 217-12-7620 79 VIRGINIA Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No WESTMINSTER MD. CARROLL Director 28s-f 10e Street and Number 10f Zin Code 10c. Citizen of What Country? ò must be 238 21157 USA. 439 MAPLE AVE. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Stetus Black, White, etc. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) AUTOMOBILE Hygions. Elementery/Secondery (0-12) College (1-4or 5+) SERVICE MANAGER REPAIR 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Pages 1 and 2 should be fit ment of Health and Mental H ant: If them 27 to marked off Be EDGAR EUGENE PARRY NETTIE ELSIE BAUMGARDNER 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other trac 439 MAPLE AVE., WESTMINSTER, MD. 21157 BETTY PARRY -WIFE 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) EVERGREEN MEM.GARDENS9/1/00 FINKSBURG, MD. 22. Name and Address of Facility FLETCHER FUNERAL HOME 21 Sin 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician tmmediete Ceuse (Finet diseese or condition resulting in deeth) /Medical CARDIAC BRRHYTH MIA IMME D Examiner Examiner ATHEROSCLEPOTIC CORONARY Sequentially list conditions, if any, leeding to immediate cause. Entar Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): The law requires that the death certificate be execu Box 68760 Physician/Medical the Due to (or es e consequence of): USB Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? P.O. 3 Probably 4 Unknown 1 Tyes 2 No ESSENTIAL HYPERTENSION Records, ğ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Certification: To Be Completed DEPENDENT DIABETES 1 Yes 2 No 1 □ Yes 2 □ No of Vital 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 DOther (Specify Euglic Yman) 1□ Yes □ Mo 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death funeral 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? After 5 Panding investigation Division or Attending 1 Tes 2 No 24 hours after death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 11 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifie (Check only one) within 2 25 29d. Date signed (Month, Day, Year) 29b. Signeture end title of cartifier 29c. License numbe 8/31/00 DO 1663 WASHINGTON 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 906C -10000 JA WESTMINSTER MD 21157 VINCENT 32. Registrer's Signeture State Registrar

**DHMH 16 Rev 6/95** 

31. Date filed (Month, Day, Year) SEP 0 1

Deneura



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day 2, 2000 Aurelia Poole September 2:00 AM 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Williamsport Homewood Retirement Center WASHINGTON If Under 1 Year 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□ M 2 F Months Days Hours Yrs 212-88-8641 9 Nov.7. 1908 Maryland Usual Rasidence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Williamsport Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Ave. 21795 USA 12. Was Decedant Evar In U,S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. l □ Yas 2 No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married Specify: White 1 Yas 2 No 3 Widowed 4 Divorced 18a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Domestic Homes 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middla, Maiden Sumema) C. Charles Poole Sadie Crowl 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 12917 Cathedral Ave. Hagerstown, MD 21742 David K. Poole, Jr. (Nephew) 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from State 4 □ Donation 5 □ Other (Specify) Riverview Cemetery Sep. 2, 2000 Williamsport, MD 21795 22. Nama and Addrass of Facility OSBORNE FUNERAL HOME P.O.Box # 348 Williamsport, MD 21795 23a. Part1. Ento the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hour t failure. List only one cause on each line. Approximata intarval Between Onset and Death Immediate Cause (Final iousulade diseasa or condition rasulting in death) Due to (or as a consequence of) Dua to (or as a consequence of): Dua to (or as a consequence of) Part If. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 | Yee 2 | No 3 | Probably 4 | Unknown 24a. Was en autopsy performed?

**Physician** /Medical Examiner

**bunial-transit** 

physician at the burial

attending use ŏ

the detached

signed by t

peen s page 2 has

certificate

Be

10

Certification:

Medical

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

filled in by

completaly

Box 68760.

Division of Vital Records, P.O.

and

**Physician** 

/Medical

Examiner

10a Stata

MD

Director

Funeral

à

Completed

0

**Funeral** 

Director

Itsm 27 is marked other than "natural", or items 23e or 28a-f show other traumatic event, the Modical Examinating must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiena. Important: If Itsm 27 is marked other than "natural", or items 28s any injury or other traumatic available.

Baltimore, Maryland 21215-0020

the Maryland

with

Examiner Sequentially list conditions, if any, leading to immediata ceusa. Enter Underlying Ceuse (Disaasa or Injury that initiated avants rasulting in death) Last Physician/Medical þ Completed

24b. Wera autopsy findings available prior to completion of ceuse of death?

1 ☐ Yas 2 ☐ No

2 No

25. Was casa ratarred to medical 28. Placa of Death (Check only ona) examinar? 1 Yas 2 No 1 inpatiant 2 ER/Outpatient 3 DOA

Other: 4 Nursing Homa 5 ☐ Rasidence 6 ☐ Othar (Specify) 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work?

5 Panding Invastigation 1 Natural 1 Yas 2 No 2 Accidant 6 Could not be datarmined 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stefa) 3 ☐ Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 - Homicide

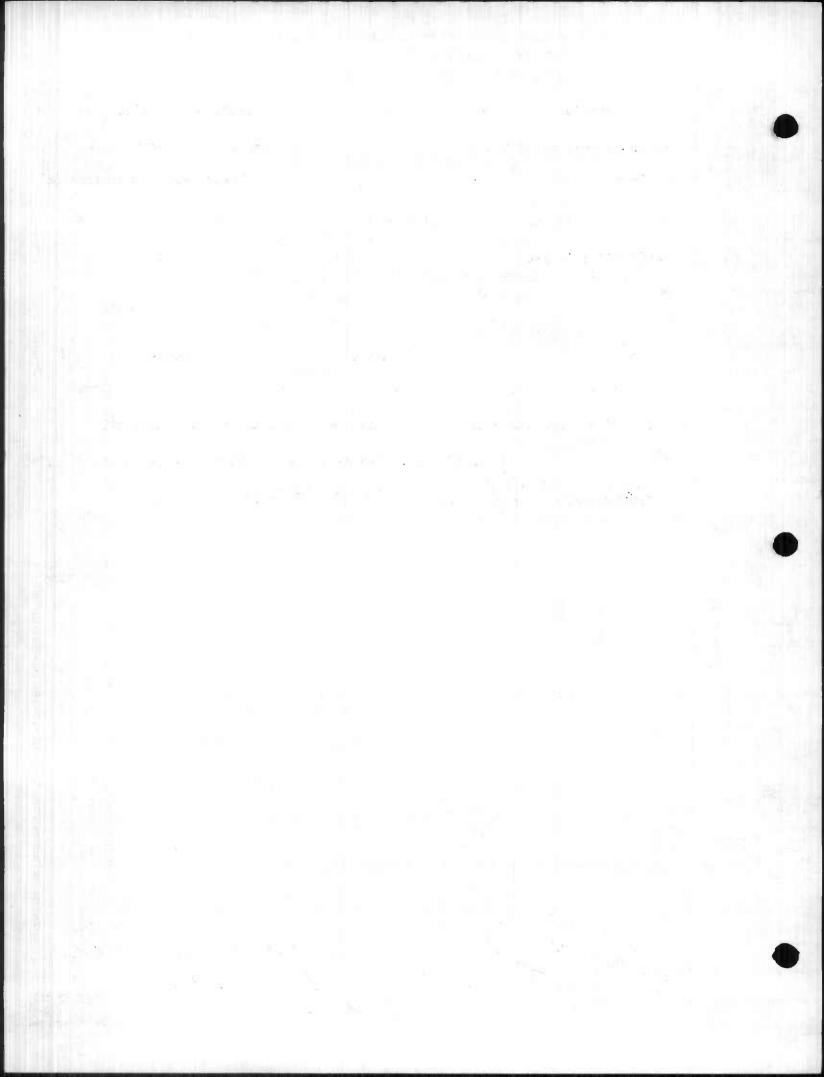
1D Certifying Physician: To the best of my knowledge, death occurred at the time, data end piace, end due to the ceuse(s) and mennar as slated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated. 29a. Certifian

29b. Signatura and title of

30. Neme ed cause of death (Item 23g) (Type, Print)

Yge forns

State Registrar

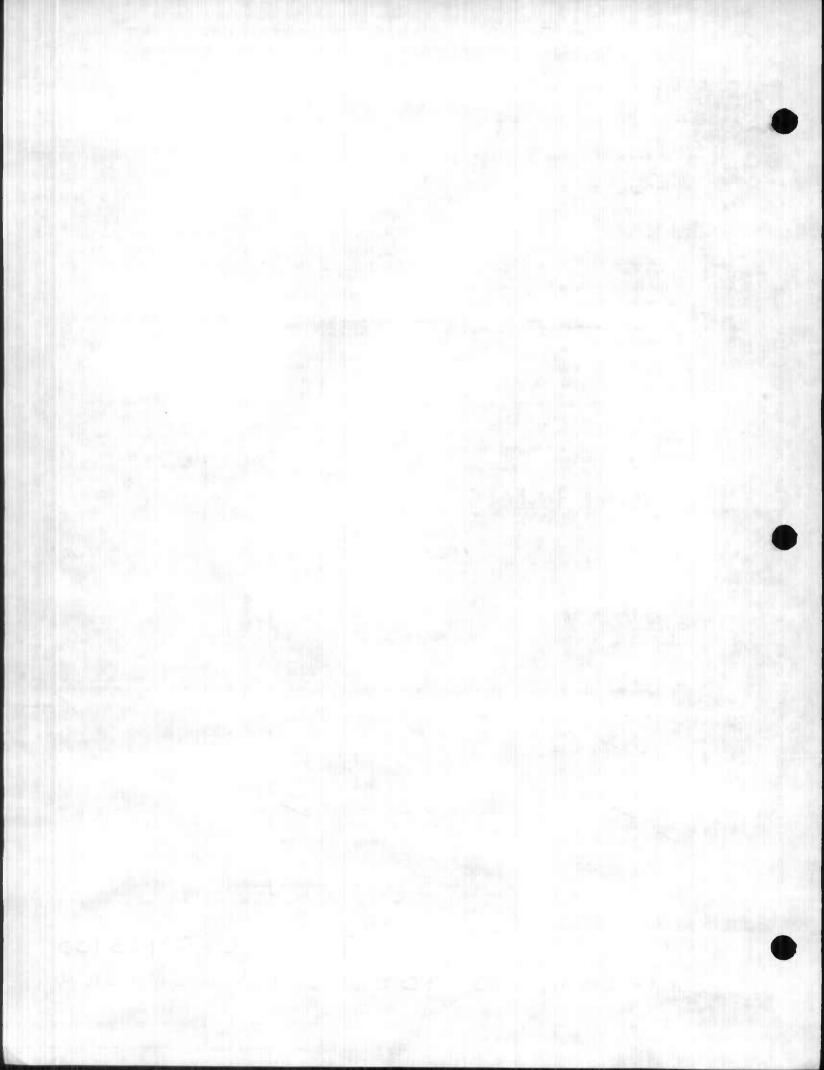


#### Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 29300

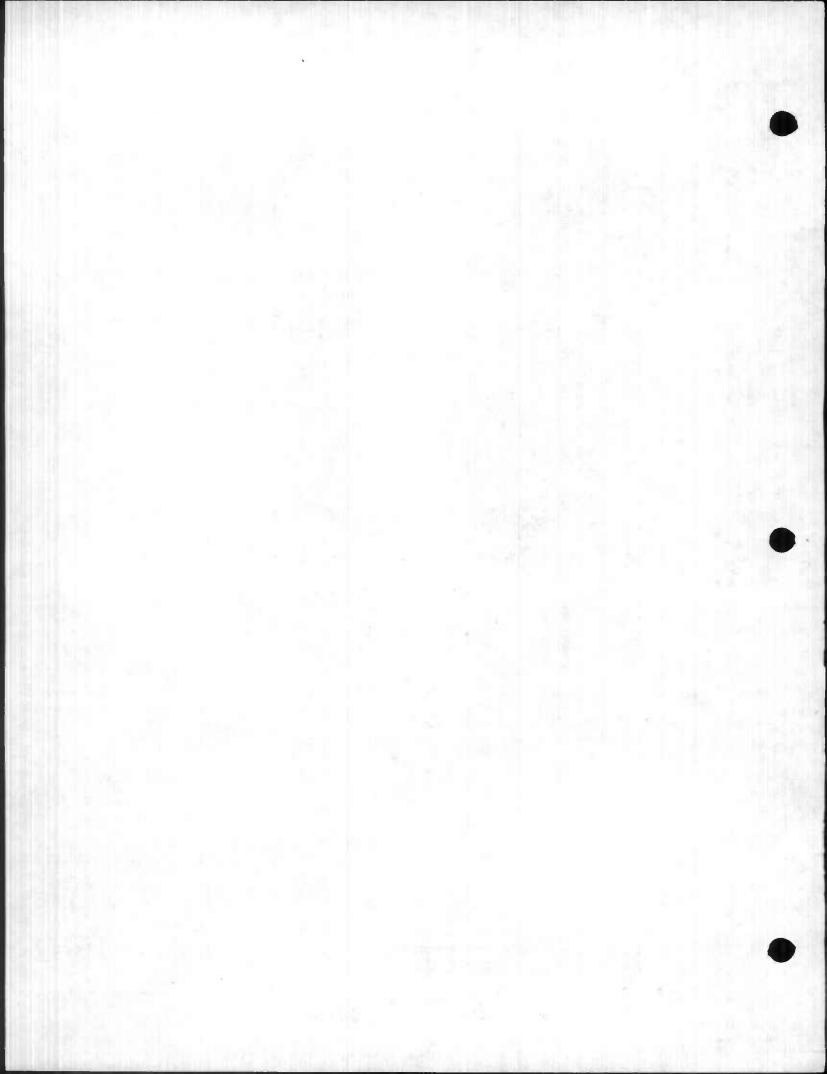
					Certifi	cate of	Death		Reg. No.	2	. 3300
D1 11 11 11		s Nama (First, Middle,	Last)			TO ST		2. Date of De			3. Time of Deeth
Physician /Medical			Rola	and E	dward	PATE	SICK	AUGUST	25 2	000	5:50 AM
Examiner			giva street and number,		ENTER		4b. City, Town, or I	ocation of Death			
			REHABILITA			Jnder 1 Year	DENTON  If Under 24 Hrs.	0 D.4- 4 Did	CARO		(0)
uneral Pirector	220-	turity Number 12-1189	5. Sex 7. Ag	ge (In yrs. las 7 7		nths Days		Jul. 1	7,1923	9. Birthplac Country Mary	
ž	10a. State	10b. County		10c. City, 7	Town or Locatio	n				10d	. Insida City Lim
or 28e-f sho be notified a Director	MD	Carol	ine			7.01	Pres		10-02		1 ☐ Yes 2 ☐X
			Bridge Ro	oad		of. Zip Code	21655		United	d Sta	tes
Examiner must Examiner must by Funeral	3 □ Wide	tatus or Married 2∑ Married owed 4 ☐ Divorced	12. Was Decedent Armed Forces  1  Yes 2  If Yes, Give Yaar or Dates:	?		Decedent of the control of the contr	Hispanic Origin? (S ean, Mexican, Puart Specify:	pecify Yas or No o Rican, etc.)	Specify	a - Amarican k, White, etc Whi	
dical dical		15. Decedent's (Specify only highest			16a. Decedent's (Give kind	of work done	during most of wor	king	16b. Kind of Bu	ısiness/Indu	stry
t, the Medical Completed	Elementer	y/Secondery (0-12)	College (1-4or	5+)	Irle. DO N	OT use retire	nd)		Autos	/Furn	iture
		8 Name (First, Middle, La	net)		291	esman		on /First Middle			Tourc
irked off		es Hynson						ame (First, Middle, Meiden Surnama) ie Dollar			
T T		int's Name/Relationship	p (Type, Print)							vn, State, Zip Code)	
27 le	Jame	s E. Patr	ick/Son		21680	Dove	r Bridg	e Rd.,	Prest	on, M	ID 2165
or other	1 💢 Buri		Removal from State	cam	a of Disposition elery, cremator ior Or	y or other pla		Date 8/28	20c. Location -		n, State larylar
E C		ation 5 ☐ Other (Spa e of Funeral Servica Lic		Outi			1				
od in	1	Milal :	7. Eskew	-	PO	Box 4	ss of Facility 1-Hawkin 3, Fede	ralsbu	rg, MD	ral H 2163	lome, F
	23a. Part1. shock,	Entar the disease, or co or heart failure. List or	omplications that cause nly one cause on each l	d the death. line.	Do not enter the	mode of dy	ing, such as cardiac	or raspiratory a	rrest,	i ir	oproximate nterval Batwaan
sician				Λ		0					Insat and Death
edical miner	disaase or o	ondition	е	H34	cratin	2 P	neunous				INK
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s been sign 2 should be pleted by		Dehylis	ih						rmed?	of de	pletion of causa eath?
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2 should	25. Was cas	Deligities e referred to medical	ih.				26. Place of Dea	perfo	Yas 2 No	of de	ath?
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and Director: After this certificate has been selected in by the funeral director, page 2 should led in by the funeral director, To Be Completed	25. Was case examine 1 Yes 27. Manner (1 Natural 2 Accided Hon 29a. Certifie (Check one)	of Death ral 5 Pending dent investiga dide 6 Could no nicide Could no	28a. Dete of Inj (Month, D) the ed 28e. Place of Int building, e	njury - At homotic. (Specify)  tot my knowled examinetion	8b. Time of Injury  e, farm, street,	28c. Inju W 1 1 cactory, office urred et the togation, In my	ther: 4 Nursing Horizont?  Yes 2 No  ime, date and place opinion, death occur	ath (Check only of loma 5 Resident of Check only of loma 5 Resident of Check on Total of Check on Total of Location (Check on Total of Location of Check on Total	yas 2 No one)  denca 6 □Oth how injury occur  Street and Numb wn, State)  cause(s) and ma date and placa,	of de 1	yes 2 No  Route Number,  led. he cause(s)
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Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	Certificate of D	Death	Reg. No.
Di di	Decedent's Name (First, Middle, Last)	2. Dete of I	
Physician /Medical	Ephraim Margarejo Rada, Sr.	Augu	7777
Examiner	4a Facility Name (If not Institution, give street end number) 4b Washington County Hospital	b. City, Town, or Location of De Hagerstown	4c. County of Death Washington County
Funeral Director	5. Social Security Number 500-64-6006 8. Sex 12M 2 F 7. Age (In yrs. last birthdey) 63 Yrs. 63 Yrs.	Hours Min. 8. Date of E	9. Birthplece (State or Foreign Country) Philippines
ZBe-f show notified at ector	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
23a or 28a-f show at be notified at al Director		- 166	1 ☐ Yas 2 ☒ No
ust be notified all Director	10e. Street and Number 10f. Zip Code 16207 Dundee Court	21740	10g. Citizen of What Country? U.S.A.
Examiner must be by Funeral I	1 Never Merried 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No	spanic Origin? (Specify Yes or In, Mexican, Puerto Rican, etc.)  Specify:	14. Race - American Indian, Black, White, etc.  Specify: Asian
rt, the Medical	15. Decedent's Educetion 16a. Decedent's Usual Occupa (Specify only highest grade completed) (Give kind of work done do	urina most of working	16b. Kind of Business/Industry
mpl	Elementary/Secondary (0-12) College (1-4or 5+)		Deblishing Commen
other traumatic event, the To Be Co	12 4 Pressman 17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd	Publishing Company  Me Meiden Sumeme)
o Be	Domfinia A Doda	Eladia Margar	
			ober, City or Town, State, Zip Code) COWn, Maryland 21740
injury or other	20e. Method of Disposition  1	Date	20c. Location - City or Town, State
ng physician and s as the burial-transit Medical Examiner		097	
detached for use a	d	on in Pert I. 23b. D	Id tobacco use contribute to the cause of death?
y Phys	Diabetes mellitus type II	1	Yes 22 No 3 Probably 4 Unknown
To Be Completed by Physician/	Diabetes mellitus type II Hypercholesterolemia		as an autopsy fromed?  24b. Were autopsy tindings available prior to completion of ceuse of death?
E O		10	☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No
Be	25. Was case referred to medicel examiner?	26. Plece of Deeth (Check on	y one)
	27. Manper of Death 28a. Dete of Injury 1 Ø Natural 5 □ Pending (Month, Dey Year) 28b. Time of Injury Work	at 28d. Describ	esidence 8 Other (Specify) se how injury occurred
completely filled in by the funera	2 Accident 3 Suicide 4 Homicide  investigation  Could not be determined  M 1 Y  28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)	Yes 2 □ No  28f. Location City or	n (Street end Number or Rural Route Number, rown, Stete)
completely filled in by Medical Certifi	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deeth occurred at the firm of check only one)	e, defe end plece, end due to the time of the time.	ne cause(s) and manner as stated. e, dete and place, and dua to the cause(s)
Мес	29b. Signature and talle at certifier 29c. License	number	29d. Date signed (Month, Day, Year)
	A LAND NY	1131	Bug. 31, 2000
	30. Name and address of person who completed ceuse of death (Item 28a) (Type, Print)	1. md. 21	740
State	31. Date filed (Month, Dey, Year)  32. Register's Signeture	1. 110. 91	7.10
Registrar	SEP 0 1 2000 Server & Sport	2	



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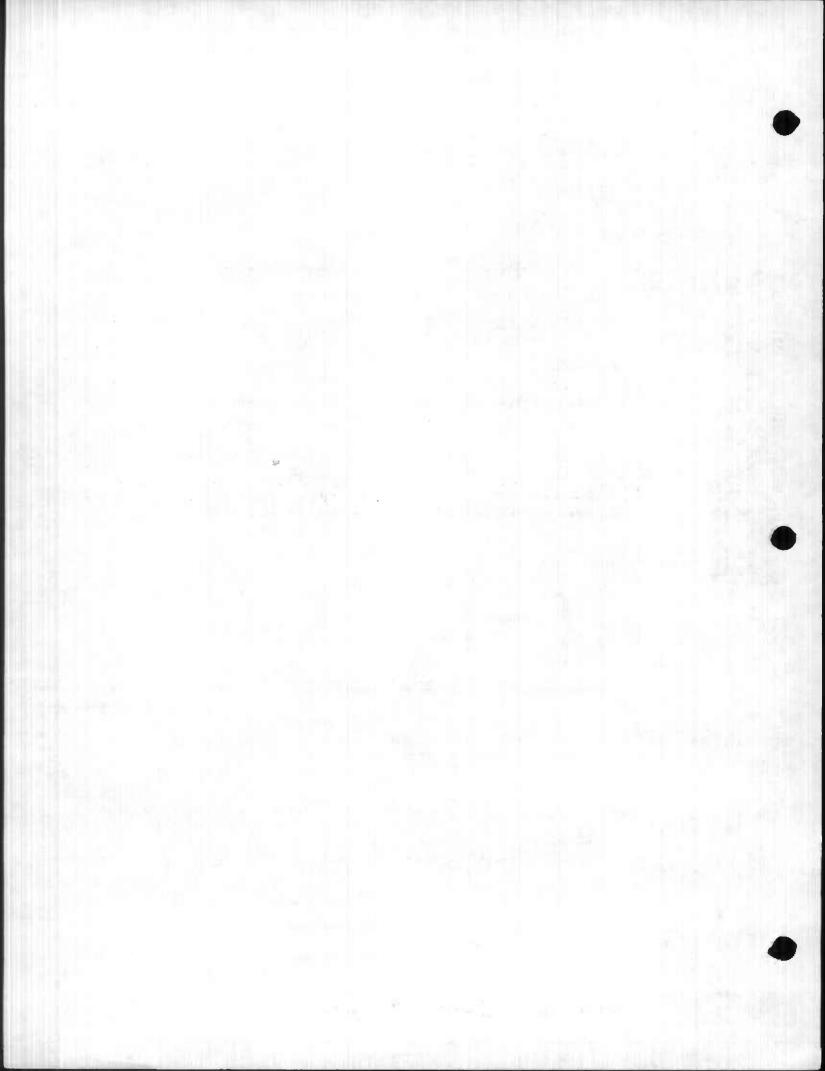
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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29302

			Cer	illicate of	Dealli	R	eg. No.			
Physician /Medical	Decedent's Name (First, Middle, La     DANIEL		ТН			2. Date of Dea Month Septembe	Day Y	3. Time of 10 11:30		
Examiner	4a Facility Nama (If not institution, given Avalon Manor Hea		r		4b. City, Town, or Lo Hagers	town	4c. County of Was	nington		
Funeral Director	215-76-5606	Sex 7. Age (In yrs. 87	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day October	22,1912	Birthplace (State or Country) Maryland	Foreign	
el show filed at	Usuat Residence of Decedent  10a. State 10b. County  Maryland Washi		y, Town or Loc gerst					10d. Inside Cit		
or 28a-f s be notified Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	at Country?		
al D	14014 Marsh Pi	ke		217	42		U.S.A			
Examiner must be notified at Examiner must be notified at I by Funeral Director	11. Marital Status  1X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		las Decedent of h Yes, specify Cub	fispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc.		
sales sel	15. Decedeni's E.	ducation	16a. Decede	ent's Usual Occup	pation		16b. Kind of Busin	ness/Industry		
t, the Medical	(Specify only highest grant Elementary/Secondary (0-12)	college (1-4or 5+)	lite. D	ind of work done O NOT use retire  TMET	during most of work d)	ing	Family	Farm		
To Be	17. Father's Name (First, Middle, Last Daniel Ir	a Roth			18. Mother's Name Rozell	а	М	iller		
TBUT.	19a. Informant's Name/Relationship (	Type, Print)			and Number or Run			mer u	24705	
Der tr	Paul M. Roth	201- 5		Cedar Ki	.dge Road,				21795	
dury or of	20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Special	Removat from State Broad	emetery, crem adfordi	etory or other ple ng Churc	h Cemeter	y 09-06-		gerstown,	Md.	
any in	21. Signature of Funeral Service Licer R. Roel A	Brady			Coffman F tietam St			c. n, Md. 217	40	
ician dical niner	23a. Part1. Enter tha disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)			Preyn		in lespitatory and		Approximate Interval Bethy Onset and D	veen Death	
use as the bunat-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting In death) Last	C	r as a consequ	1000				1		
	Part II. Other significant conditions of	dcontributing to death but not resi	ulting In the un	derlying cause giv	ven in Part I.	23b. Did to	obacco use contr	ibute to the cause o	of death?	
Physiciar						10Y	es 2 No 3	Probably 4	Unknown	
; page 2 should be detached for Completed by Physicia						24a. Was a perfor		24b. Were autopsy fi available prior to completion of ce of death?	0	
E C	and the second					10 Y	es 20 No	1 Yes 2	No	
Be C	25. Was casa raferred to medicat				26. Place of Deat			10166 201	140	
ToB	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient	3□ DOA Ott			ence 6 ☐Other	(Specify)		
in by the funeral director, page ertification: To Be Com	27. Mannar of Death   Second Sec	28a. Data of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju			ow injury occurred			
led in by the funera Certification:	3 Suicide 6 Could not b 4 Homicida determined			et, factory, office		28f. Location (S City or Town	treet and Number n, Steta)	or Rural Route Numb	ber,	
pletely fill edical								o the cause(s) and manner as stated. time, data and place, and due to the cause(s)		
No No							9d. Date signed (	Month, Day, Year)		
	· W	m 2_		1 244	996		Sept-5	2000		
	30. Name and address of person who 2 year Malik	completed cause of death (Item	1 - 1	int)	Rd Bo	zonsbr	vo M	D 21713		
State Registrar	31. Date filed (Month, Dey, Year) SEP 0 5 2	32. Registrar's Signa	ture &	Spor	h					



edical Certification

5 Pending investigation

6 Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Accident

3 Suicide

29a. Certifier

4 Homlcide

29b. Signature and title of certifier

31. Dete filed (Month, Day, Year)

SEP 1 5 2000

Mary G. Ripple, M.D.

23a. Part1. Enter the disease, or shock, or heart feilure. List a	complications that ceused the death. Do not enter the mode of dylng, such as cardiac only one ceuse on each line.	or respiratory arrest,	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SMOKE INHALATION AND GUNSHOT WOUND OF HEAD.  Due to (or es e consequence of):		
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying	b		
Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence of):		
Part II. Other significant condition	ne contributing to death but not resulting in the underlying ceuse given in Part I.	23b. Did tobacco use con	atribute to the cause of death?
		24a. Wes an eutopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of death?
		1 Yes 2□No	1 Vyes 2□ No
25. Wes case referred to medicel examiner?		h (Check only one)	
10(Yes 2□ No	Hospitel: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Ho	me 5 Residence 6 10th	er (Specify) SCENE
27. Manner of Death  1 Netural 5 Pending	28a. Date of Injury 28b. Time of 28c. Injury at Work?	28d. Describe how injury occur fire and a gunshot	red subject victim of

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

1 Yes 2√XNo

28f. Location (Street and Number or Rural Route Number, City or Town, State) Villages of Urbana 3501 Urbana Pike, Frederick County, Md.

29d. Date signed (Month, Dey, Year)

AUGUST 29, 2000

7:29 AM

1 XYes 2 No

Registrar

oaks

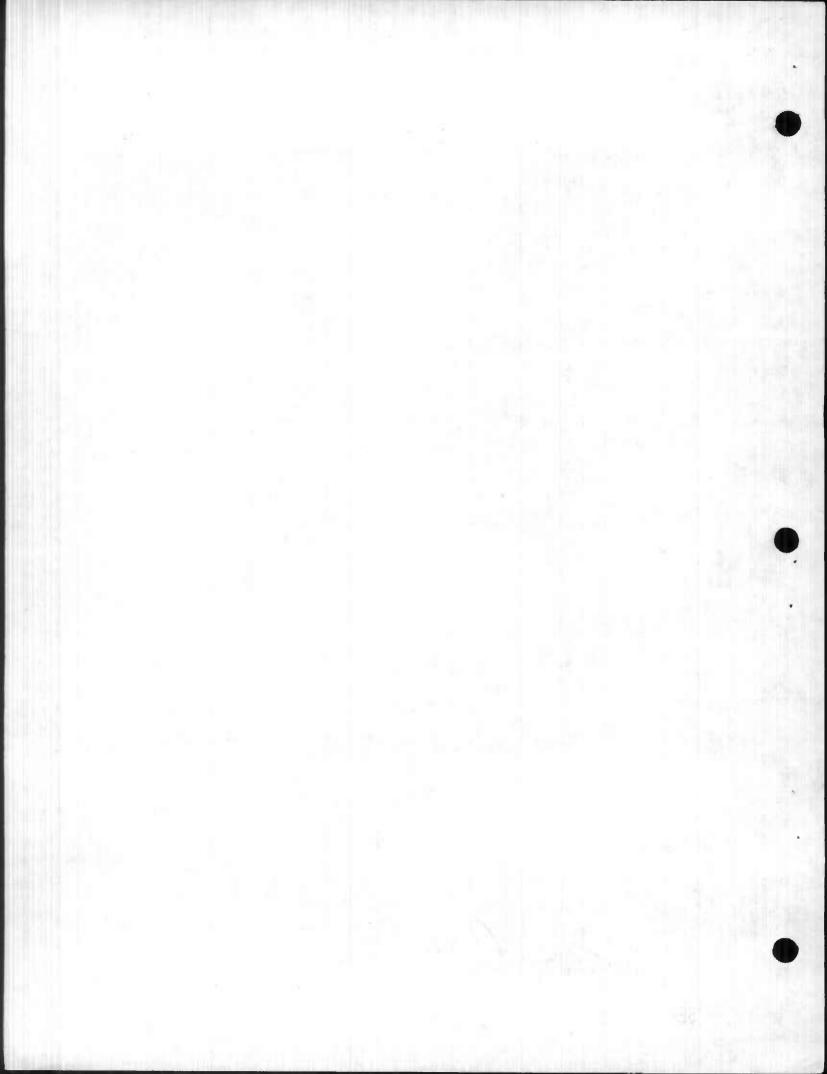
found:

7:17

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) found: in vehicle in undeveloped area

8/28/00

32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** LAURENCE SMITH WILLIAM Q 1413 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner BERLIN WORCESTER ATLANTIC GENERAL HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthpleca (Stete or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 753M 20F Min. Months Hours 77 Yrs. 166-14-5315 Director PA Usual Residence of Decedent 10a State 10c. City. Town or Location 10b. County 10d. Inside City Limits MD. BERLIN YYes 2 No Director WORCESTER 238-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21811 200 WEST ST. U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Delyes 2 □ No if Yes, Give Yeer or Detes: WW I I 14. Reca - American Indian, 11. Merital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify Specify: WHITE à 3 ₩idowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade com al Hygiene. College (1-4or 5+) Elementery/Secondary (0-12) MANAGER TRAILER PARK 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) thould be to work the transfer of the transfer JOHN CRONIN CATHERIN JOHNSON 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 arment of Health an ROBERT BRENNER 200 WEST ST. BERLIN, MD. 21811 Health Item 27 i 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 O'Cremation 3 Removel from Stete SALISBURY CREMATORY 9-7 SALISBURY, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signetured Fugural Service Lices 22. Name and Address of Facility ULLRICH FUNERAL HOME BERLIN, MD. 21811 23a. Rant-Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as e consequence of) encestive Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Due to (or es e consequença of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24e. Was en autopsy performed? 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 1 Yes ZW No 1 (Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manuar of D 1 Natural er of Death 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending 1 ∏Yes 2 □ No death. investigation 2 Accident Director 3 Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of contiling

State Registrar

**DHMH 16 Rev 6/95** 

WILLIAM

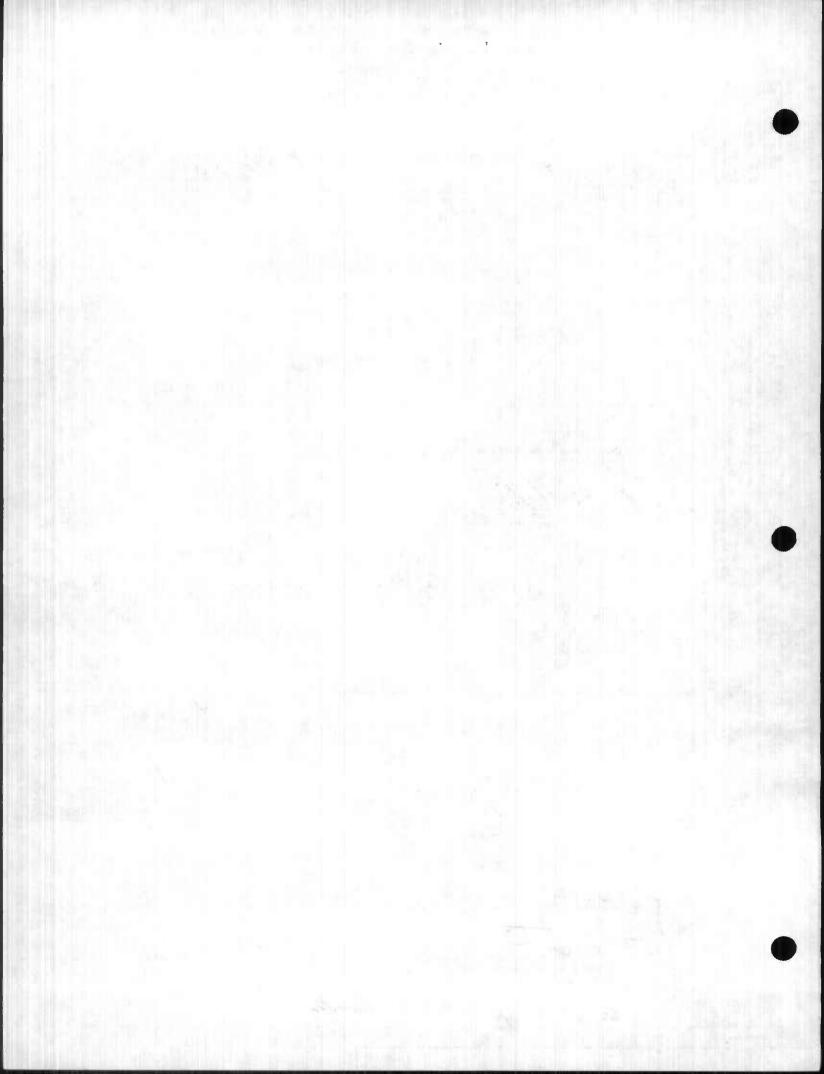
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31. Date filed (Month, Day, Year)

OVLTIMAT 32. Pagistrer's Signature 2000

Name and address of person who completed cause of death (Item 23e) (Type, Print)

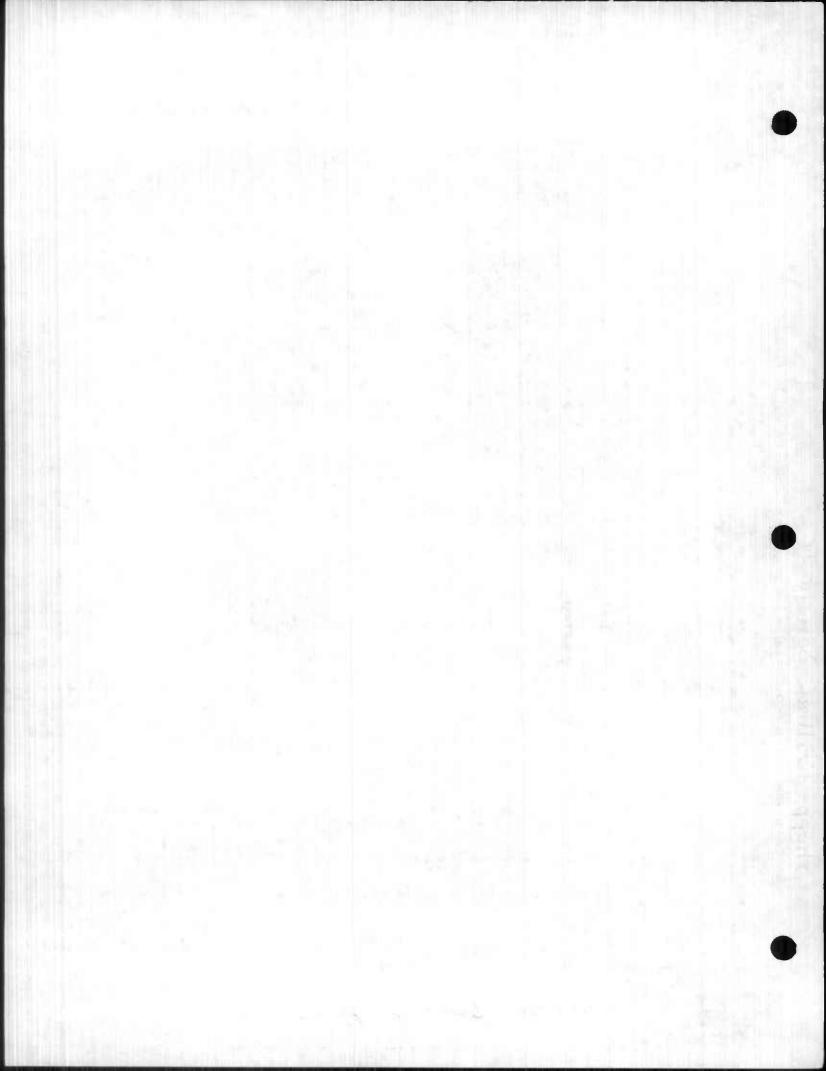
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75.75.013				Cer	tificate o	r Death		Reg. No.			
Physician	1. Decedent's Name (First, Midd	Ne, Last)		CHILDO	I.D.		2. Date of Do	Day	Year	3. Time of Death	
/Medical	4a Facility Name (If not institution			SHUPP	JR	4b. City, Town, or	Location of Deal		2000 of Death	3:50 Ph	
Examiner	Washington			1		Hagers			shin	gton	
Funeral	5. Social Security Number	6. Sex 7	Age (In yrs. I		ff Under 1 Yes			th ay, Year)	9. Birthpl Count	ace (State or Foreign	
ector	220-64-6372 Usual Residence of Decedent	X ** 201	45	Yrs.			August 1	gust 16,1955   Maryland			
show rd.st	10a. State 10b. County	1	10c. City	, Town or Loc	eation				10	d. Inside City Limits	
28e-f st notified rector	Maryland Was	shington	H	lagers	town					1 Yes 2 □ No	
7 B	10e. Street and Number		10g. Citizen of	What Coun	ry?						
here 23e per men	402 South Mu	lberry St:		6 40 4	217		Sanaite Man as Al	U.S.A. y Yes or No- 14. Race - American Indian,			
Funeral	11. Merital Stetus 1 ☐ Never Married 2 ☐ Ma	f Hispanic Origin? (Suban, Mexican, Puer	to Rican, etc.)		ck, White, e	etc.					
by	3 ☐ Widowed 4 ☐ Divorce	If Yes Give		1	□Yes 2XIN	o Specify:		Specif	y:Whit	ce	
Completed	15. Decede	nt's Education est grade completed)		16a. Deced	ent's Usuai Occ	upation e during most of wo red)	rking	16b. Kind of B	usiness/Ind	ustry	
mpl	Elementary/Secondary (0-12)	College (1-4c	or 5+)			r⊕d) Operatoi		Black	Ton S	ealing Co.	
ပိ	11 17. Father's Name (First, Middle	Last)		OWITE	1 4114	18. Mother's Na				sarring co.	
To Be C	William	Donald	S	hupp	Sr.	Barba	ara	Ann	М	oats	
	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailin	g Address (Stre	et and Number or R	urel Route Numb	er, City or Town	, Stete, Zip	Code)	
ner traum	Dorothy K.	Shupp				lberry St					
or other tri	20a. Method of Disposition  1 D Buriat 2 CCremation	3 □Removal from Sta	te Ce	emetery, crem	sition (Neme of setory or other p		Date	20c. Location			
any injury or once.	4 Donation 5 Other (		Smo		rg Crema		8-31-20			g, Maryla	
any le	21. Signature of Funeral Service Licenses  Andrew K. Coffman Funeral Home, Inc.										
	40 East Antietam Street, Hagerstown, Mo. 21/40 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate										
ician	shock, or heart tailure. List only one cause on each line.  Interval Between Onset and Death										
ical iner	Immediate Causa (Finat disease or condition Respiratory Arrest										
	resulting in death)		Due to (or	r as a consequ	fonce of).		1	0.	1		
al Examin		b	ULTI	pee as a consequ	puem	onary	embo	120	i		
edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	H	-11501- 4-1	CO291	111	stal	+				
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use as the buria		d	ung	Ca	rcino	ma					
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detached for u	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							b. Did tobacco use contribute to the cause of death?  1 1 Yes 2 No 3 Probably 4 Unknow			
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. page 2 should be Completed by							24a. Wa per	s an autopsy omed?	ava	re autopsy findings illable prior to appletion of ceuse	
mple								3	of	leath?	
rector, page								Yes 2 No	10	Yes 2 No	
director.	25. Was case referred to medical axaminer?	Hospital: 1 🗷 Inpa	ationt OU	ER/Outpatient	3□ DOA	)ther:	ath (Check only		has (Canaih	4	
-	27. Manner of Death	28a. Date of It		28b. Time of	28c. In		T	how injury occu		/)	
he fune ation	E C MOOIOOM	igation	Day reary	Injury		Yes 2 No					
pletely filled in by the funera edical Certification:	3 Suicide 6 Could determ	nined 286. Place of	Injury - At ho etc. (Specify		et, fectory, offic	90	28f. Location City or To	(Street and Num own, State)	ber or Rure	l Route Number,	
	29a. Certifier 15X Certifyi	ng Physician: To the be	at of my know	wladea doeth	occurred at the	time date and place	and due to the	causa(s) and m	anner er el	atad	
To the Funeral Directory filled in b		Examiner: On the basis and manner	of examinat	ion and/or inv	estigation, in my	y opinion, death occi	urred at the time	, date and place,	and due to	the cause(s)	
Me	29b. Signeture and title of partition 29c. License number							29d. Date signed (Month, Dey, Year)			
	Marcadoru MD D 4556					15563		Augu	st:	30, 2000 erstown 1	
	30. Name and address of person			23a) (Type, I	Print)	+ 0+	0 4	0.00		+	
			UD	324E	Anue	tam St.	Suite	203	Hag	erslown A	
State Registrar	31. Date filed (Month, Day, Year AUG 3	1 2000	Stray's Signer	Lure /	9 10	ake			V	21/4	
The second second	11000		,-	/	1-1-	4.1					



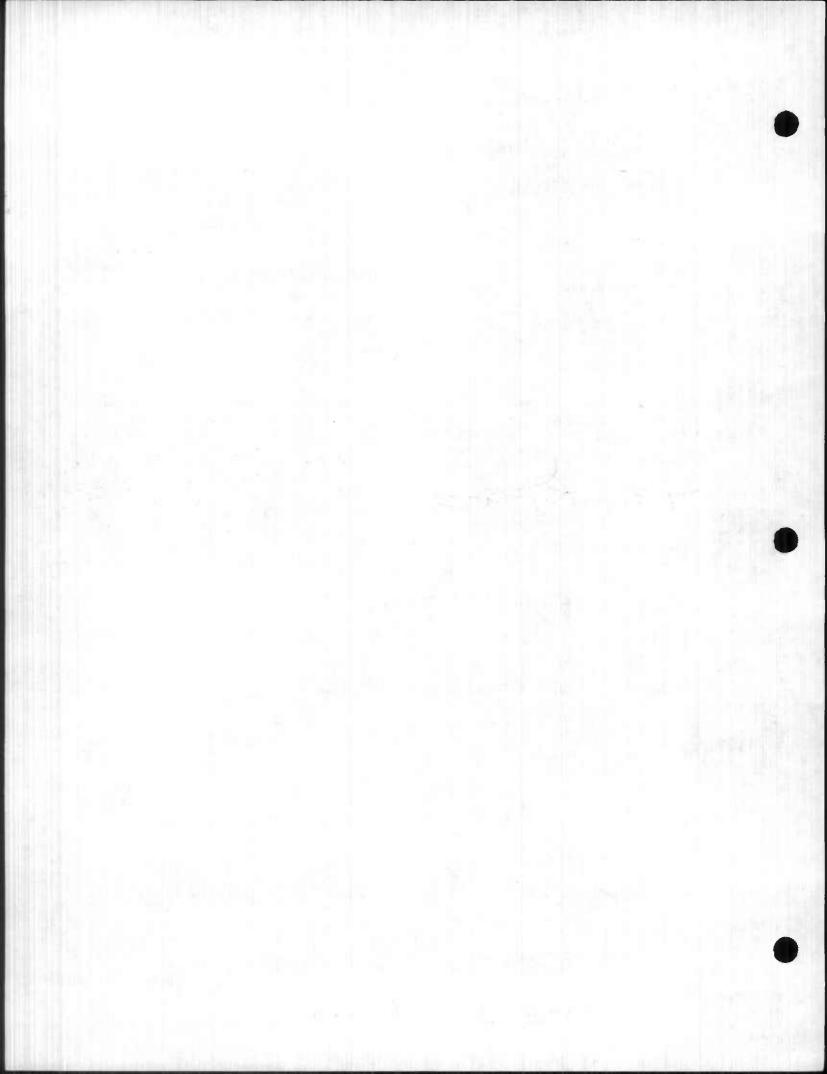
# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 9 3 0 6 Reg. No. 3. Tima of Death Month Month Month Month Month August 28 2000 10:40 A.

	Physician	1. Decedent's Neme (First, Middle, Lest) Paul Bernard Stouter Sr.								2. Date of Death Month Day Year 3. Time of Death				
ξ,	/Medical							th City Taylor	Augus or Location of Deet		2000	10:40 A.M		
	Examiner			Ave. Apt.	209			Emmits			Frede	rick		
	Funeral Director	5. Social Security N	Number 6. S		a (In yrs. last b		If Under 1 Yaar Montha Days	If Under 24 H	rs. 8 Data of Bi	27,1939		place (State or Foreign Xyland		
T	P .	Usual Residence o	f Decedent 10b. County		10c. City, To	wo or Local	tion					Od Incide City Limite		
15-0020  72 hours after death with the Maryland *natural*, or flams 23s or 28s-f show added Examiner must be notified at	r show	Md.	Frede	rich	Toc. City, To		tsburg				10d. Insida City Limits 1X☐ Yas 2☐ No			
	Tect	10e. Street and Nu		- DCCIC	101. Zip Code					10g. Citizen of What Country?				
	23a or	401 W.	Lincoln	Ave. Apt.	ve. Apt. 209 21			727	U.S.A.					
	filed within 72 hours after deat Hygiene. Infor than "natural", or thems a ent, the Medical Examiner in e. Completed by Funer		ried 2 Married	Armed Forcas?  1  Yea 2  If Yas, Giva	1   Yea 2   Yeo   1   Yes 2   Xeo			oan, Mexican, Pu	o- 14. Race - American Indian, Black, Whita, alc. Specify: White					
9	n 72 hours aft metural", or after Eram leted by F	3 Widowed	15. Decedent's E	Yeer or Detaa:	16	a Deceder	it's Usual Occu	nation	16b. Kind of Businass/Industry					
21215-0020	be filed within 72 ho tal Hygiene. I other than "naturi event, the Medical Be Completed		cify only highest gra	ida completed)		(Giva kir	of work done NOT use retin	one during most of working						
	d with	Elementary/Sec	ondary (U-12)	College (1-4or 5	Maintenance				2			Treatment Center		
nd	build be filed Mental Hygi srked other atic event, To Be Co		(First, Middla, Last,								na)			
ya	should Ind Mening Market		d Henry S											
, Maryland	and 2 should be filed within n 27 la marked other than ner traumatic event, the last traumatic event, the last traumatic event, the last traumatic event, the last traumatic event, the last traumatic event, the last traumatic event, the last traumatic event, the last traumatic event eve		lame/Ralationship ( et Stoute		40	01 W.	Lincol			a Number, City or Town, State, Zip Code) 209 Emmitsburg, Md. 21727				
altimore,	Pages 1 ment of H ant if Ner ary or oth	20a. Method of Disposition  20b. Place of Disposition (Nama of cematary, crematory or other place)  20b. Place of Disposition (Nama of cematary, crematory or other place)  Smiths burg Crematory  20c. Location - City or Town, State  20c. Method of Disposition (Nama of cematary, crematory or other place)  Smiths burg Crematory  20c. Location - City or Town, State  20c. Method of Disposition (Nama of cematary, crematory or other place)  Smiths burg Crematory  20c. Location - City or Town, State												
Ball	permit. Pe Department Important any Injury office.	21. Signature of Fr	unioral Service Lice	- Jaw	5		lama and Addr is Fune	ass of Facility ral Home		Bradbury burg, Md				
		23a. Pert1. Entar i	tha diseasa, or com	plications that caused ona cause on each li	I tha death. Do	not entar	tha moda of dy	ing, such as card				Approximata Intarval Batween		
	Physician /Medical Examiner	Immediata Causa diseasa or condition rasulting in death)	(Final	. metasta		m Su	nall cul				in	Onset end Deeth		
	executed in and ital-transit	Sequentially list co	onditions,	b										
68760,	eath certificate be executed attending physician and for use as the burial-transit clan/Medical Examir	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last  Dua to (or as a consequence of):  Dua to (or as a consequence of):												
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ŭ	death e atter ed for u	Part II Other plani	ficent conditions o	ontributing to death h	ut not resulting	in the und	articipa causa a	iven in Part I	23h Did	tobacco uma co	otribute t	o the cause of death?		
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Ke	8 8 0											death?		
Vital	centificate h rector, page	25. Was casa refa	red to medical					00 Di 41		Yes 2 No	11	Yas 2 No		
	Physicien: The I this certificate he ral director, page : To Be Com	axaminar?		26. Place of Death (Check only one)  Hospital: 1   Inpatient 2   EP/Outpatient 3   DOA   Other: 4   Nursing Homa 5   Residence 6   Other (Specify)							hu)			
0 5 5 7	27. Manner of Dear		28a. Data of Injury (Month, Day Year)  28b. Tima of Injury M 1   Yes 2   No											
DIVISION C below Attending P as after death. el Director: After t ied in by the funars Certification:		3 Suicide 4 Homicide	6 Could not b detarmined	28a. Place of Injury - At home, farm, atreet, factory, office building, atc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)										
Hospi 4 hou Funer taly fill	he Hospital in 24 hours he Funerel pletaly filled edical C													
	To the comple	29b. Signatura and	I titla of certifier	7016	MI	)	29c. Licen	se number	4	29d. Data signe				
		30. Nama and addi	rass of person who	completed causa of d	eath (Item 23a)	(Type, Pri	501	W 7	th stree	t Frede	NCK	MD 2174		
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Registrar

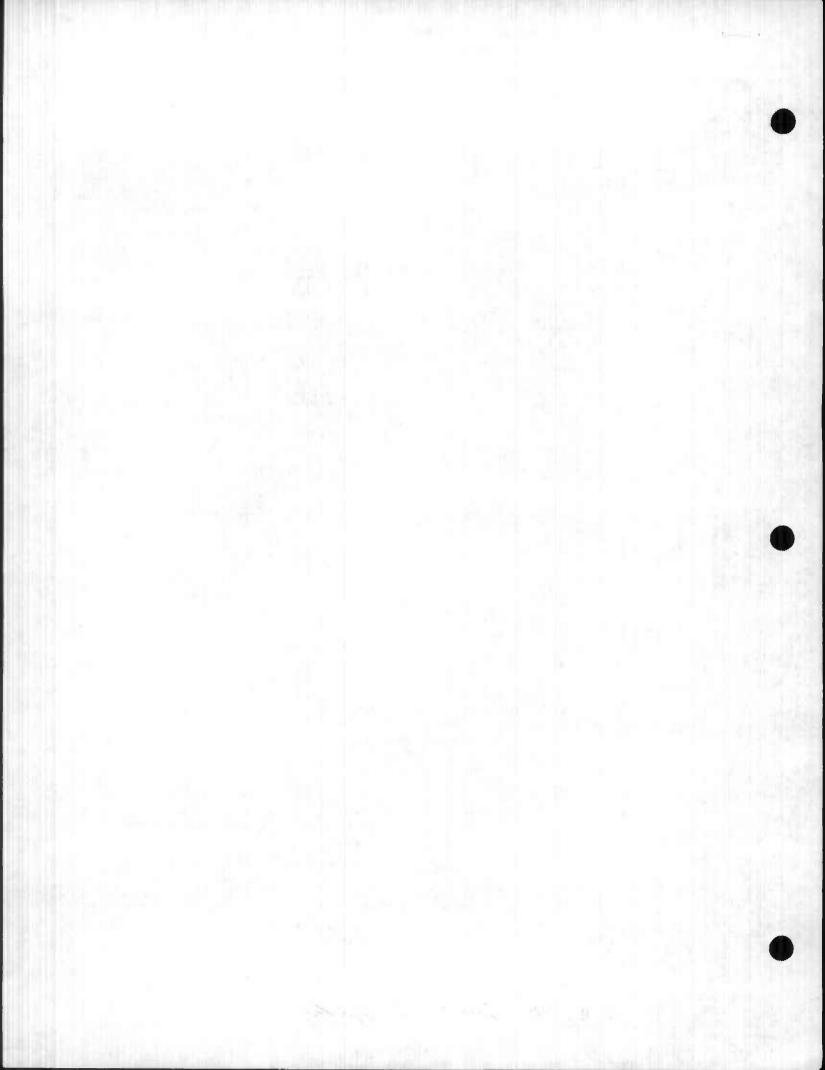
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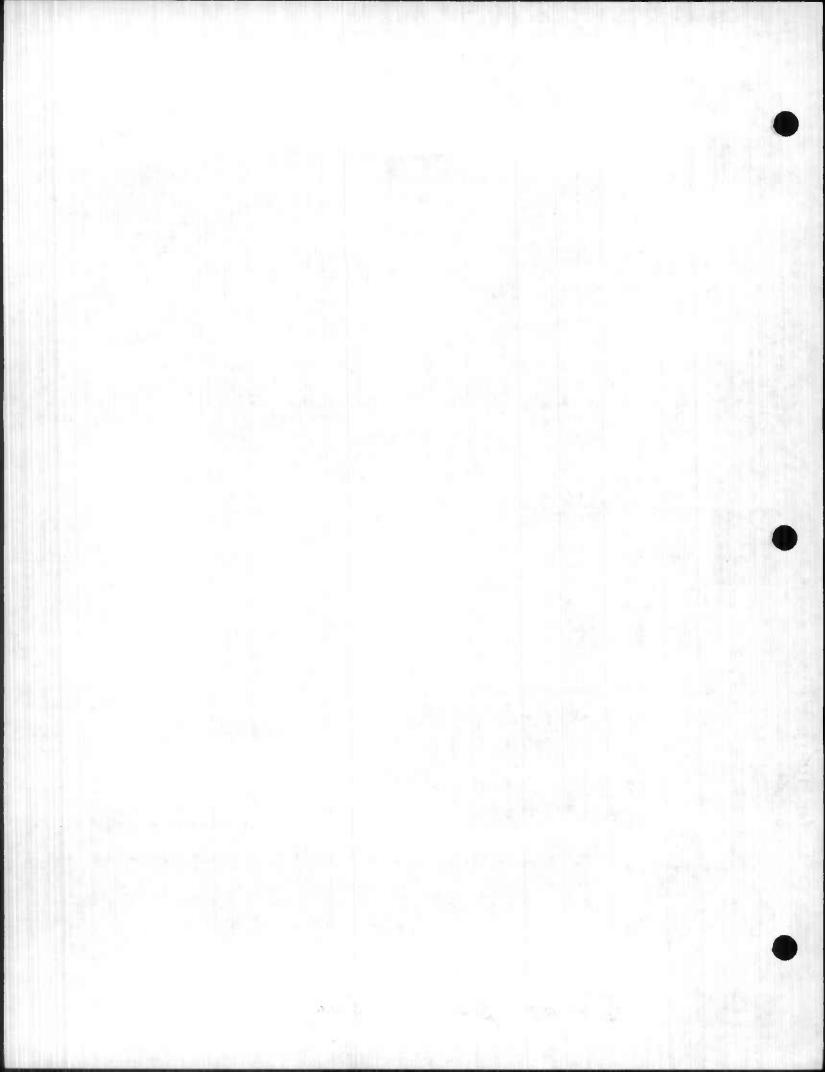
State of Maryland / Department of Health and Mental Hygiene Lines 5.. WCHD/Sept. 5, 2000/SC 19b. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** tragust 1218 HERMAN ELDEN STOCKSLAGER 30, 2000 4c. County of Death /Medical 4b. City, Town, or Location Death 4a Facility Name (If not institution, give street and number) Examiner Washington County Hospital Washington County Hagerstown If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) May 5, 1937 5. Social Security Number 6 Sax 7. Age (In yrs. lest birthday) **Funeral** Days Months Hours 1⊠M 2□F 212-38-8977 63 Yrs. Maryland Director 212-38-9095 Usuel Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits MD Washington Co. Hagerstown 1 ☐ Yes 2 X No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 2 mast be n 19767 Leitersburg Pike 21740 U.S.A. 21742 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 8 White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) uges 1 and 2 should be filed within it of Health and Mental Hyglens. If them 27 is marked other than or other traumatic event, the M Elementary/Secondary (0-12) College (1-4or 5+) Farming Farmer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Della Pearl Wolfinger Herman Lamont Stockslager 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 21742 19a. Informant's Name/Relationship (Type, Print) 19767 Leitersburg Pike, Hagerstown, Maryland 21740 Thelma Jean Stockslager/Wife 20b. Piace of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages artment of 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Sept.2 Waynesboro, Pennsylvania Green Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 reuclos A > is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, see on each line. Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Occhusion 504 den COVONAVY Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, Completed by 24b. Were autopsy lindings available prior to 24a. Was an autopsy completion of cause of death? X No 1 Yes 1 Yes 2 No Be 25. Was case referred to medicel examiner? 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To 1 Yes 2 No 28b. Time of 28d. Describe how injury occurred 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? Certification: Division 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation death Director 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) after 4 Homicide within 24 hours. To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00 completed ceuse of death (Item 23a) (Type, Print) 598 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State SEP 01 2000 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



Physician  Naty Ariane Taylor  Sections of Deals  Mary Ariane Taylor  Sections of Deals  Mary Ariane  For action in the first interest of the section of the				(	Certificate of	f Death		Reg. No.	23300
Former    Purpose   Purpos	Physician			.1			Month	Day Year	
Washington County Hospital  Sout Story Mark Plant  South Story Mark Plant  Sou	/Medical			<u> </u>		4h City Town or I	sentem	her 3, 2000	
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The property of the property o			412		Months Day		8. Dete of Bir (Month, Da Octobe	th 9. Bit (Y. Year) C (T11, 1925 Ma	ountry)
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18 Burlie   2   Commission   Signature of Fine   Specially   Sept.	e, M 1 and 2 Health ther tri		ryor - daugh	20b. Plece of D	Disposition (Name of				
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Physician Medical Examiner  The property of th	- MINIST	23a. Pert1. Enter the disease, or shock or heart failure. List	complications that cause	ed the death. Do no					
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1   Yes   22   No   1   Impatient   2   ER/Outpatlent   3   DOA   Manner of Death   1   Wetural   5   Pending   Investigation   3   Suicide   4   Homicide   28a. Date of Injury   M   1   Yes   2   No   28b. Time of injury   M   1   Yes   2   No   28b. Time of injury   M   1   Yes   2   No   28b. Describe how injury occurred   28b. Describe how injury o	Vita Vita iclan: centific rector.	examiner?	/	13 1		Wher:			
2   Accident 3   Suicide 4   Homicide   Street and Number or Rural Route Number.   28e. Place of Injury - At home, farm, street, fectory, office   28f. Location (Street and Number or Rural Route Number. City or Town, State)   29a. Certifier (Check only one)   Certifying Physician: To the basts of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.   29b. Signeture end title of certifier   29c. License number   29d. Date signed (Month, Dey, Year)   29d. Date signed (Month,	Phys Phys oral di		1) Inpat		atient 3D box	4 🗆 Iduising in			ecify)
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20. Name and address of person who completed cause of death (from 22a) (Type Brint)	To the within To the compl	29b. Signeture end title of certifie			29c. Lice	nse number		29d. Date signed (Mor	th, Dey, Year)
			3 / Salaran						2
Elilozh Lo Urstido Ton Contra Hospital		30. Name and address of person	who completed cause of	death (Item 23a) (To	vpe, Print)	D2231	13	7-	-3-00
State Registrar  SEP 0.5 2000  32. Registrar's Signeture  SEP 0.5 2000		1 5/10 0	who completed cause of	death (Item 23a) (Ty		D2231	13   TAL	7-	-3-00

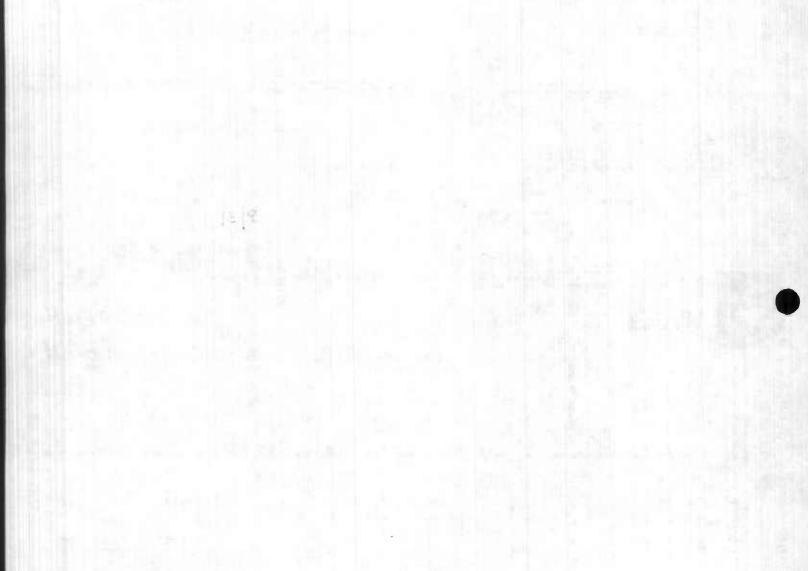


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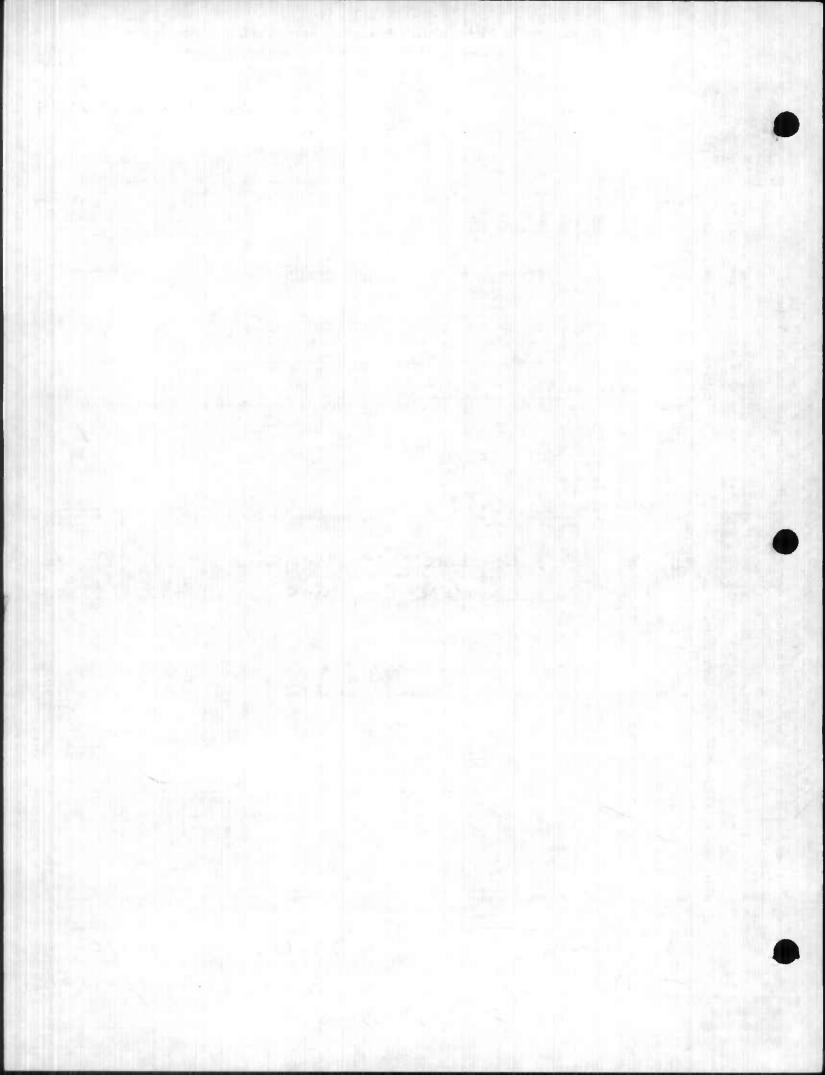
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nd / Department of Health and Mental Hy	ygiene	0	0	2	9	3	n	9
Certificate of Death	Reg. No.	,		free		0	0	~

MYRTLE MAE THOMAS  August 26, 2000 9:00 P  August 26,				Certificate of	Death	Re	g. No.	23003
TRIED HOTELS  TAIDOT HOSPICE	Physician	1. Decedent's Name (First, Middle, Last						
Talbot Inospice  Talbot			MYRTLE MAE	THOMAS			26, 200	00 9:00 PM
\$ Seed Secrety Number    Seed Secrety Number   Colored	4a Facility Name (If not Institution, give	street and number)		4b. City, Town, or L	ocation of Death	100		
Space   Spac			ce			1		
The State of Talbot   10c. Chry Town or Location   10c. Chry Town or Location   10c. Chry Town or Location   10c. The Dode   10c. Chry Town or Location   10c. Ch		AF	7 60	Months Days		(Month, Dey,	9. E 3,1910 1	Birthplace (State or Foreig Country) Maryland
MD Talbot Easton  10 / 26 Code   2 .		10.05					Land to the contract	
### 1980 Leeds Landing Road    Part	Maryes Find at for				aston			1 ☐ Yes 2 ☑ No
1. Martial Status   1. M	Se or 25s of be not	10e. Street and Number	ling Road		601			
1.0 Notice of the process of the p	me 2		12. Wes Decedent Ever in U,S.				14. Raca - Ai	merican Indian,
1. Name're Steemer, Avoid, Modow, Leth   William Wallace Owings   Valid Woodfield   William Wallace Owings   Valid Woodfield   Sets of Deposition   130. Marring Address (Street and Number or Rural Rouse Number, City or Town, State, Zip Code)   Betsy Olystemetics   3D. Removal from State   All Docations   City Code   Secsion   No. 2   Sets of Deposition   130. Walling Address (Street and Number or Rural Rouse Number, City or Town, State, Zip Code)   Betsy Olystemetics   3D. Removal from State   All Docations   City Code   Secsion   No. 2   Sets of Deposition   130. Walling Address   Street and Number or Rural Rouse Number, City or Town, State, Zip Code)   Date   Code   Secsion   No. 2   Sets of Deposition   Name of canteely, certainly or Orimer Places)   Code   Secsion   Name of canteely control of Code   Secsion   Name of canteely control or Orimer   Sets of Code   Secsion   Name of Code   Name o	,	3€Widowed 4 □ Divorced	1 Yes 2 No			Rican, etc.)		
William Wallace Owings Lydia Woodfield  19. Informan's Name-Relationship (Type, Prof.)  Betsy O'Brien/Daughter 3801 Leeds Landing Rd., Easton, MD 21601  19. Whended Obsposition 1, Removal from State All-Obsacions 1, Other (Specific Comment) 1, Removal from State All-Obsacions 1, Other (Specific Comment) 2, Removal from State All-Obsacions 1, Other (Specific Comment) 2, Removal from State All-Obsacions 1, Other (Specific Comment) 2, Removal from State All-Obsacions 1, Other (Specific Comment) 2, Removal from State All-Obsacions 1, Other (Specific Comment) 2, Removal from State All-Obsacions 1, Other (Specific Comment) 2, Removal from State All-Obsacions 1, Other (Specific Comment) 2, Removal from State All-Obsacions 1, Other (Specific Comment) 2, Removal from State All-Obsacions 1, Other (Specific Comment) 2, Removal from State All-Obsacions 1, Other (Specific Comment) 2, Removal from State All-Obsacions 1, Other (Specific Comment) 2, Removal from State All-Obsacions 1, Other (Specific Comment) 2, Removal from State All-Obsacions 1, Other (Specific Comment) 2, Removal from State All-Obsacions 1, Other (Specific Comment) 2, Removal from State All-Obsacions 1, Other (Specific Comment) 2, Removal from State All-Obsacions 1, Removal from S	dical	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Decedent's Usuel Occu (Give kind of work done	pation during most of work	ing 1	6b. Kind of Busine	ss/Industry
15. Mainter's Name (Prist, Modos, Later)   16. Mainter's Name (Pri	nen a Me	Elementery/Secondary (0-12)					O.W.	n Home
William Wallace Owings Lydia Woodfield  19a. Informant's NameRelationship (Type, Pert)  19b. Informant's NameRelationship (Type, Pert)  20b. Mendod of Disposition  1 (Nameria (Special)  20b. Mendod of Disposition  1 (Nameria (Special)  20b. Mendod of Disposition  1 (Nameria (Special)  20b. Manage and Address of Pacility  12b. Signature of Funders Service Licensee  12b. Manage and Address of Pacility  21b. Signature of Funders Service Licensee  12b. Manage and Address of Pacility  22a. Pert I. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respectively street.  22a. Pert I. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respectively street.  22a. Pert I. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respectively street.  22a. Pert I. Enter the disease, or condition.  22b. Manage and Address of Pacility  10b to (or as a consequence of):  22b. Use to (or as a consequence of):  22b. Use to (or as a consequence of):  22b. Was a subject fording the street of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the caus	C Harie	12		Homemake		- /Pi A findelin Ad		II IIOIIIE
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PO Box 43, Federal sburg, MD 21632  23a Parti. Finite of dieses, or compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate infleval services, or heart failure. List only one cause on each line.  Due to (or as a consequence of):  Liver Causes  Due to (or as a consequence of):  Liver Causes  Due to (or as a consequence of):  Liver Causes  Due to (or as a consequence of):  Due to (or	ant: If its ury or of	1 D Burial 2 Cremetion 3 DF	Removal from State	netery, crematory or other ple				
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Immediate Cause (Fine)   Immediate Cause (Fi		23a. Part1. Enter the disease, or comp	lications that caused the death.					Approximete
Immediate Cause (Final deases or conditions resulting in death)  The total form of the second form of the se	hvsician	shock, or near trailure. List only o	ne cause on each line.					
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1   Yes 2   1   No.   3   Probably 4   Unkin   24a. Was an autopsy performed?   24b. Were autopsy finding available prior to completion of cause of destin?   1   Yes 2   No.   1   Yes 2   No	£ 5	resulting in death) Last	Due to (or a	s a consequence or).				
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1   Yes   2   No   3   Probably   4   Unkin	for for					ant Dutant		
24a. Was an autopsy performed?  24b. Were autopsy finding available prior to completion of cause of death?  1   Yea 2   No	y the	Part II. Other significant conditions con	ntributing to death but not resulti	ng in the underlying cause gi	ven in Part I.			
25. Was case referred to medical examiner?    1	de de de					1 1 10	s ZIETNO 3L	Probably 4 Unkno
25. Was case referred to medical examiner?	been sign should be							available prior to completion of cause
25. Was case referred to medical examiner?  1	has pe 2					400	down	_/
27. Manner of Death 1   Inpatient 2   ER/Outpatient 3   DOA   27. Manner of Death 1   President 3   Suicide 4   Homicide   28a. Dete of Injury   28b. Time of Injury at Work? 1   Yes 2   No   28b. Time of Injury at Work? 1   Yes 2   No   28c. Injury at Work? 1   Yes 2   No   28d. Describe how Injury occurred   28d. De	Co pa							1 Yea 24 No
27. Manner of Death 1   Inpatient 2   ER/Outpatient 3   DOA   27. Manner of Death 1   President 3   Suicide 4   Homicide   28a. Dete of Injury   28b. Time of Injury at Work? 1   Yes 2   No   28b. Time of Injury at Work? 1   Yes 2   No   28c. Injury at Work? 1   Yes 2   No   28d. Describe how Injury occurred   28d. De	ecto Be	examiner?	Hospital:	100	her:			
29a. Certifler (Check only one)  29a. Certifler (Check only one)  29b. Signature and title of certifler  29b. Signature and title of certifler  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Mathew Fischer  20b. Detailed (Month, Dey, Year)  29c. License number  29d. Date signed (Month, Dey, Year)	F SE	1 162 22 140	1 Unpatient 26 E	Voutpatient 3LI DOA	4 LI Nursing Fi			Specify)
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Matheway Fischer  20c. Certifier  29c. License number  29d. Date signed (Month, Dey, Year)	The Co	1 Natural 5 Pending	(Month, Day Year)			28g. Deacribe no	w injury occurred	
29a. Certifler (Check only one)  29a. Certifler (Check only one)  29b. Signature and title of certifler  29b. Signature and title of certifler  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Mathew Fischer  20b. Detailed (Month, Dey, Year)  29c. License number  29d. Date signed (Month, Dey, Year)	the the	2 LJ AWIOGIN						
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Matheway Fischer  29c. License number  29d. Date signed (Month, Dey, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Matheway Fischer  29d. Date signed (Month, Dey, Year)	1 2 E	dataminad	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, factory, office		28f. Location (Str City or Town	eet end Number or , Stete)	r Rural Route Number,
Matthe Fisher 10 D52251 8/24/00  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Mathew Fisher 2 Martin Court - Guite / Euston May land 2160/	Funeral Cell Cal Ce	(Check only 2 Medical Exami	ner: On the basis of examination					
Matthew Fischer 10 D52251 8/2°/00  30. Name and address of person who completed cause of death (Item 23a) (Typo, Print)  Matthew Fischer 2 Martin Court - Guite / Euston May land 2160/	Thin 2		and manner stated.	29c ticen	se number	20	d Date signed /M	onth Day Year)
25 Date filled (Stanth Day Year) 20 Deviated Circuity	1 0 0 T	290. Signature and title of certifier		1 a			4	,
75 Date filled (Streeth Pay Vent) 20 Decistored Circulus		matthe ,	wieks 1	D	92251		0/24/	00
21 Date filled (Month Day Year) 20 Decisional Company		30. Name and address of person who come the schere of the	ompleted cause of death (Item 2  2 Markin	3a) (Type, Print)  Our - Suit	6/ Eu	ston 1	Very land	2160/
	State	31. Date filed (Month, Dey, Year)	32. Registrar's Signatur	10				

DHMH 16 Rev 6/95



					Cel	uncau	e or i	Death			Reg. No.		
	1. Decedent's Nam	ne (First, Middle, La	st)							2. Date of De Month		Year	3. Time of Dea
Physician /Medical	Helen	T. Turner								Augus		2000	1043
Examiner		If not institution, giv LA REGION			CER		4		wn, or Loc ISBUR	cation o Death	4c. County	of Death	0
Funeral Director	5. Social Security N 221-10-9	851	Sex I□M 20 F	7. Age (fn yrs. la:	Yrs.	If Under Months	1 Yeer Days	If Under: Hours	Min.	8. Date of Bird (Month, Da 2-23-19	y, Year)	9. Birthp Coun	lace (State or For try) DE •
1	Usual Residence of	10b. County		10c, City,	Town or Loc	cation						1	0d. Inside City Lir
a or 28a-f ahow Lbe noursed at Director		Sussex		Laur									1 ☐ Yes 2)X
r tems 23s or 23s-f s her must be nourse Funeral Director	Rt. #5 B					10f. Zip	Code 1995	6			10g. Citizen of W USA	/hat Coun	itry?
, A	Widowed	ried 2 Married	12. Was Deced Armed Form 1 Tes 2 If Yes, Give Yeer or Da	2 No		Vas Deced f Yes, spec l □ Yes		ispenic Orlan, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)	14. Race Blace Specify.	k, White,	an Indian, etc. White
natur dical	(Spec	15. Decedent's Ec			16a. Deced	kind of wo	rk done o	durina most	of working	ng	16b. Kind of Bu	siness/Inc	dustry
ygiene. Nor than "naturi It, the Woolcal Completed	Elementary/Seco		College (1-	4or 5+)	Cashi	DO NOT us	se retired	1)			Food		
王智	17. Father's Name	(First, Middle, Last)		134113							Maiden Sumam		
marked o	William	E. Taylo									it Taylo		
t de la la la la la la la la la la la la la		Musser,		r						De. 19	97, City or Town,	State, Zip	Code)
nent of Health ant: If Item 27 ary or other to		position Cremation 3  5 Other (Specification)		tate cen	metery, crem Fe110	natory or o	ther plac		8-	Date 23-00	20c. Location - Laurel,		wn, State
Department of Important: If any injury or once.	21. Signature of Fu	Quara Service Licer	1500	lot	22.	Shor	t Fu		Hom	e, Inc.	19956		
nysician Medical kaminer	Immediate Cause disease or condition resulting in death)	on	one cause on ea	Due to (or a						rrespiratory a	rrest,		Approximate Interval Between Onset and Deat
physician and a the burial-transit		inditions, nmediate eritying i Injury s Last	b	Due to (or a	as a consequal as a consequ	uence of):	pA	we				1 1 1	ming
use sa			0.										
for for		licent conditions o	O	th hut not social	ling in the con			an in Dark I		Oak Did	Inhana usa aar		the enuse of de
by the atterached for ached for thysician	Part II, Other signif	ficant conditions o	ontributing to dea	ith but not result	ting in the ur	nderlying c	euse giv	en in Part I				1	
gned by the attending be detached for use at by Physician/Me	Part II, Other signif	ficant conditions c	ontributing to dea	ith but not result	ting in the ur	nderlying c	euse giv	en in Part I		1 🗆		3 Prof	bebly 4 Unk
has been signed by the atter ge 2 should be detached for a mpleted by Physicial	Part II, Other signif	ficant conditions c	ontributing to dea	ith but not result	ting in the ur	nderlying c	euse giv	en in Part I		1 🗆	an autopsy	3 Prof	bebly 4 Unk
has been signed by the attending pe 2 should be detached for use at mpleted by Physician/Me	Part II. Other signif			ith but not result	ting in the ur	nderlying c	euse giv			1 🗆 24a. Was perfo	an autopsymmed?	3 Prof	ere autopsy findialable prior to mpletion of causideath?
his certificate has been signed by the atter al director, page 2 should be deteched for To Be Completed by Physicial	Part II. Other signif	rred to medical	Hospital: 1 DA	patient 2 E	EP/Outpatien 28b. Time of Injury	nt 3 DC	Oth OA Oth Wor	28. Place er: 4 □ Nu y at k?	of Death	24a. Was perfection of the second of the sec	an autopsymmed?	3 Prof	ere autopsy finding allable prior to mpletion of causideath?  Yes 2 No
leath.  To: After this certificate has been signed by the atter the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for catlon: To Be Completed by Physicial	Part II. Other signif	rred to medical	Hospital: 1 Den	patient 2 E	R/Outpation 28b. Time of Injury	at 3 DC	Oth OA Oth Wor	28. Place er: 4 □ Nu	o of Death ersing Hon	24a. Was perfo	an autopsymmed?  Yes 2 [] bloomed?  Yes 2 [] bloomed?  Street and Numb	3 Prol 24b. Wi av co of 1[	bably 4 Unk ere autopsy findir ailable prior to mpletion of cause death?  Yes 2 No
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wher death.  Director: After this certificate has been signed by the atter in by the funeral director, page 2 should be detached for in  stiffication: To Be Completed by Physicial	25. Was case referexaminer?  1 Yes 2 2  27. Manner of Deat 1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)	th  5 Pending Investigation 6 Could not be determined	Hospital: 1 Dan 28a. Date of (Month) 28a. Place obuildin systelan: To the banner: On the ba	patient 2 Ei	EP/Outpatien 28b. Time of Injury ne, farm, stre	M 2 M occurred	OA Oth  OA Oth  Wor  1   //, office  at the tin, in my o	28. Place er: 4 Nu y at k? Yes 2 I	o of Death prising Hon 2 No 2	24a. Was perfo	an autopsymmed?  Yes 2 □ No one)  dence 6 □ Oth how injury occurr  Street and Numb wn, State)  cause(s) and ma	3 Proid 24b. Www.co.of 1[ er (Specificed) are or Rures and due to	mpletion of cause death?  Yes 2 No  No  No  Route Number,  tated.  the cause(s)
4 hours after death.  **Linerel Director: After this certificate has been signed by the atter- iely filled in by the funeral director, page 2 should be detached for it iely filled in by the funeral director, page 2 should be detached for it ical Certification: To Be Completed by Physicial	25. Was case referexamine?  27. Manner of Deat 1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)	rred to medical  th  5   Pending investigation 6   Could not be determined	Hospital: 1 Dan 28a. Date of (Month) 28a. Place obuildin systelan: To the banner: On the ba	patient 2 Elinjury, Day Year) of Injury - At homog, etc. (Specify) best of my knowless of examination er stated.	EP/Outpatien 28b. Time of Injury me, farm, stre fledge, death on and/or inv	M 2 M 2 M 2 M 2 M 2 Document factory	OA Oth  OA Oth  Wor  1   //, office  at the tin, in my o	28. Place er: 4 Nu yat k? Yes 2 Inne, date an pinion, dea	o of Death prising Hon 2 No 2 d place, a	24a. Was performed to the service of the control of	an autopsymmed?  Yes 2 [] Moone)  Idence 6 [] Other  Anow injury occurr  Street and Numb  wn, State)  cause(s) and ma  date and place, it	3 Proid 24b. W. av co of 1[ array ar	ere autopsy findia allable prior to impletion of causideath?  Yes 2 No  No. 14 Route Number, itated. o the cause(s)



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Delete item#28a,b,c 8-22-00 Certificate of Death bh 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death MEREDITH VENEZIA 1505 4b. City, Town, or Location of Death 2000 20 Nama (M not institution, give street and number) ALLS TON KEN. 4c. County of Death HOSPITA L Fallston Harford If Undar 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Data of Birth (Month, Day, Year) Months Days 1□M 2XF 213-20-1737 78 July 18, 1922 Canada Usual Rasidence of Decedant 10c. City, Town or Location 10d. Inside City Limits 10a. Stata 1 Yas 2 No Maryland Harford Edgewood 10a. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 803 Green Briar Ct. 21040 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puarto Rican, atc.) Race - American Indian, Black, Whita, atc. 11. Marital Status 1 Yas 22 No If Yas, Giva Yaar or Datas: 1 Never Married 2 Married 1 Yas 2 No Specify: Specify 3X Widowed 4 ☐ Divorced White 16a Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) 12 Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Surname) (u/k)(u/k) Cunningham Hammond Patricia 19a. Informant's Name/Raletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 13419 Haddonfield In., Darnestown, Maryland 20878 Patricia Shifflett / Daughter 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20e. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata Donation 5 ☐ Other (Specify) Zion U.M. Cemetery 8-24-00 Bel Air, Maryland 22. Nama and Addrass of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingo and tissasa, or complications that caused the death. It is an an analysis of dying, such as cardiac or respiratory arrest, filters. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximata Interval Batween Onset and Death Immediata Causa (Final disaasa or condition rasulting in death) SEPSIS Dua to (or as a consequence of): ETABOLIC ACIDOSIS - SHOCK Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last ERFORATED ILIUM. Dua to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown F COLON-TOST (RRADIATION 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Wes case referred to medical examiner? 26. Placa of Deeth (Check only ona)

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

23a or 28a-f show

death Herma

filed within 72 hours after

Peges 1 end 2 should be

Baltimore, Maryland 21215-0020

the Medical Examiner must be notified at

6

Hygiene.

and Mental h

other

Department of Health a Important: if item 27 is any injury or other tracents.

Director

Funerai

by

Completed

o

Medical Certification: To

Physician/Medical Examiner þ Be Completed

or Attending after death. in by within 24 hours a To the Funeral C Hospital To the

Division

104

Registrar

31. Data filed (Month, Day, Year)

29b. Signatura and titla of certified

1 Yes 2 No

5 Panding

invastigation

6 Could not be

27. Manper of Death

1 W Naturel

2 Accident

3 Suicide

29e Certifier

4 Homicida

ATTENDING

Hospitel: 1 Inpatiant 2 ER/Outpatient 3 DOA

28b. Tima of Injury

28a. Place of Infury - At homa, farm, streat, factory, offica building, atc. (Specify)

1505PM

28a. Date of Injury (Month, Day Year)

20/200

00012870

28c. Injury at Work?

1 Yas

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year)

281. Location (Street and Number or Rural Routa Number, City or Town, State)

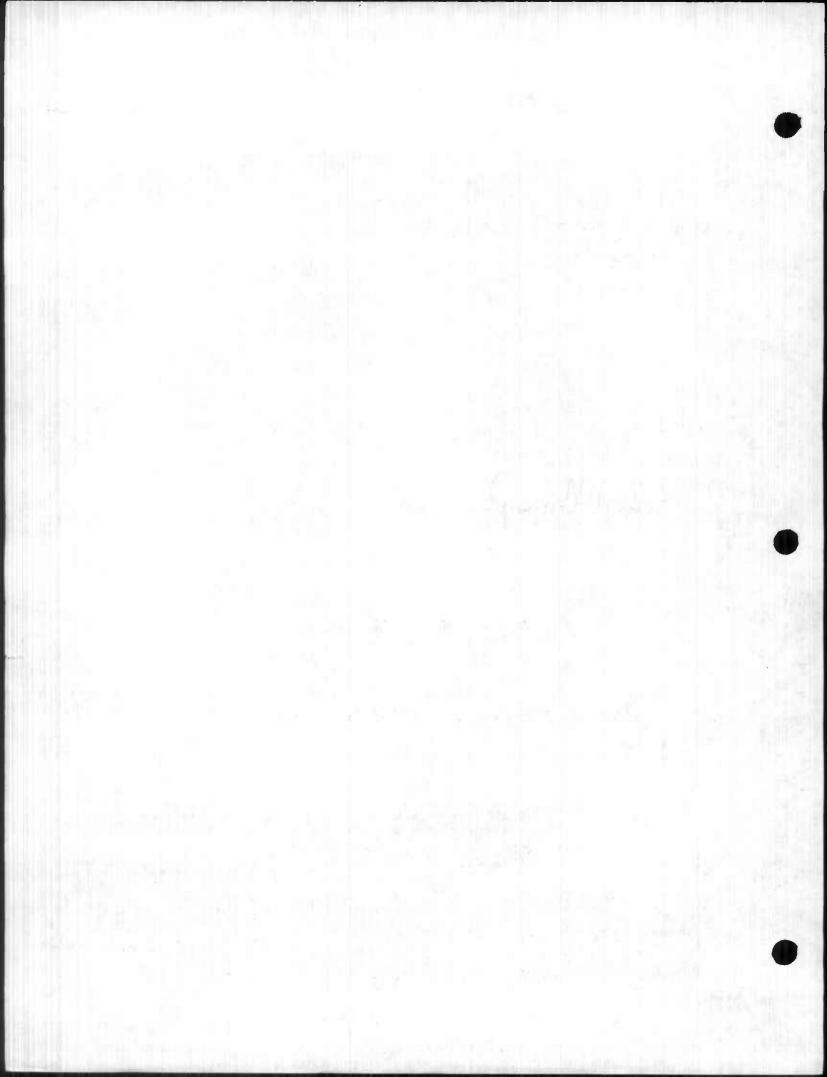
causa of death (Itam 23a) (Type, Print)

NRES HT, H.D. 501- DOCPHIN St. BACT. 21217 Md.

Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify)

28d. Dascribe how injury occurred

32. Registrar's Signature AUG 2 2 2000



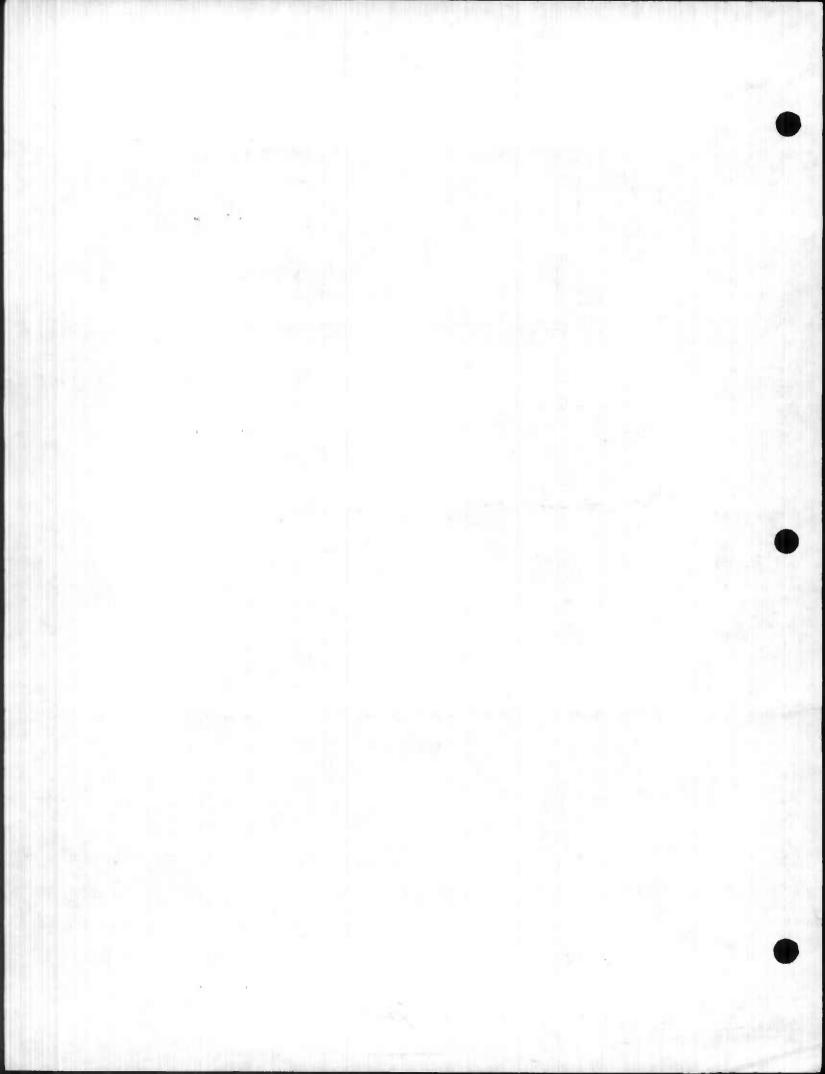
	23a,ptII,27per			E	Cel	tificate of	Death		Reg. No.	0 29,	016
Physician /Medical	1. Decedent's Neme (F	WALLACE	EFIRE				4h Cihi Tour	2. Date of De Month Septem	Day ber 05,	Year 2000 5:	ne of Death  35 P.M.
Examiner	4a Facility Name (If no 12824 Be			"			Cumber		Alleg		
Funeral Director	5. Social Security Num 216 38 132	ber 6. S	ex 7. A	Age (In yrs. la.	st birthday) Yrs.	If Under 1 Yea Months Days		Hrs. 8. Date of Bir Min. (Month, Da JAN 19	th v, Year)	9. Birthpiece (Si Country) MARYLANI	ate or Foreign
deeth with the Maryland me 23e or 28e-f show Linual be notified at		ocedent 0b. County ALLEGAN	Y		Town or Lo				pE		de City Limits Yes 文景 No
3a or 28a-f a	10e. Street and Number 12824 BEDF		O, NE			10f. Zip Code 21	502		U.S.	What Country?	
urs after aff, or the Execute by Fur	11. Marital Status  1 XNever Married  3 Widowed 4 C		12. Was Deceder Armed Forces 1  Yes 2 If Yes, Give Year or Dates	s? ] No	1	Wes Decedent of f Yes, specify Cu I ☐ Yes 2 1 No	ban, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)		e - American India ck, White, atc.	
ied within 72 hours tygiene. *** *** The Medical Exit. The Medical	(Specify	. Decedent's Ed only highest gra	ucation de completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of wor			of working	16b. Kind of Bi	usiness/Industry	
iene. then the M	Elementery/Seconda	ary (0-12)	College (1-4o	r 5+)	Iffe. DO NOT use retired)  LABORER				BREWER	Y	
be filed tal Hygid d other avent, II Be Cc	17. Fether's Neme (Fir.	st, Middle, Last)					18. Mother	s Name (First, Middle	Meiden Sumen	ne)	
s 1 and 2 should be filed f Health and Mental Hyy frem 27 is marked othe other traumatic avent, TO Be C	NORMAN WAI	LLACE					REBA	LEE WITT		70	
2 sho and le m	19e. Informent's Name/Relationship (Type, Print)  19b. Meiling Address (Street and Number or										
of Health Health Hem 27 other tr	ROBERT WAI		BROTHER			VALLEY R sition (Name of	OAD, BE	EDFORD, PA	4	City or Town, Sta	to
permit. Pages. Department of I Important: If He any Injury or of	20a. Method of Dispos 1 X Burial 2 C 4 Donetion 5 [	Cremetion 3 □	Removal from Stel	te cer	metery, crer	natory or other pi		RY 9/9/00		AND, MD	
Physician /Medical Examiner	Immediate Cause (Fin diseese or condition resulting in death)	allure. List only	e. CARDIAC I	HYPERTRO			ying, such as c	ardiec or respiratory e	rrest,		al Between and Death
certificate be executed ding physician and ise as the burial-transit	Sequentially list conditit any, leading to imme cause. Enter Underly! Cause (Disease or injuthat initiated events resulting in deeth) Les		b	Due to (or	es e consec	uence of):					
				Due to (or	as e c <i>on</i> seq	uence of):					
d by the atter stached for u	Part II. Other significa	nt conditions o					given in Part I.		tobacco use co Yes 2 ☑ No	ontribute to the ca	
es that the deeth igned by the atter be detached for u by Physiciar	Part II. Other significa	nt conditions o					jiven in Part I.	1 🗆		3 Probably  24b. Were auto available	4 Donknown
The law requires that the deeth ate has been signed by the atterpage 2 should be detached for underged by Physician	Part II. Other significa	nt conditions o					given in Part I.	1 □	Yes 2 No	3 Probably  24b. Were auto available completio	4 Donknown
The law requires that the deeth rate has been signed by the atterpage 2 should be detached for u	Part II. Other significa	nt conditions of	ZOPHRENIA			nderlying cause (	26. Place e	1 □	Yes 2 No en eutopsy primed?  Nes 2 □ No	3 Probably  24b. Were autoavailable completio of death?	4 Donknown
Physician: The law requires that the deeth this certificate has been signed by the atterral director, page 2 should be detached for u. To Be Completed by Physician.	Part II. Other significa  MORBID OBES  25. Was case referred exeminer;  10 Yes 2 No  27. Manner of Deeth  12 Natural	nt conditions of	Hospitel: 1 ☐ Inpa	but not result		nderlying cause of the state of	26. Place o	24e. Wesperful  1 Department of Death (Check only sing Home 5 Res 28d. Describe	Yes 2 □ No en eutopsy rmed?  Nes 2 □ No one)	3 Probably  24b. Were autravailable completion of death?  1 Des	4 Donknown
or Attending Physician: The law requires that the deeth that death.  Sirector: After this certificate has been signed by the attent in by the funeral director, page 2 should be detached for use the funeral director, page 2 should be detached for user if the funeral director.	Part II. Other significa  MORBID OBES  25. Was case referred exeminer?  12 Accident	nt conditions of	Hospitel: 1 Inpa  28a. Dete of Ir (Month, I	but not result	ER/Outpatier 28b. Time o' Injury	nderlying cause of the state of	26. Place of the control of the con	24e. Wes perfect of Death (Check only sing Home 5 Res 28d. Describe o	Yes 2 No en eutopsy primed?  Hes 2 No cone)  dence 6 € Ott how injury occur	3 Probably  24b. Were autravailable completion of death?  1 Des	4 Punknown  opsy findings prior to n of cause  2 No
fing Phyelcien: The law requires that the deeth h.  After this certificate has been signed by the atter funeral director, page 2 should be detached for ution: To Be Completed by Physician	Part II. Other eignifica  MORBID OBES  25. Was case referred exeminer?  Yes 2 No  27. Manner of Deeth  12 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier  10	ant conditions of STTY; SCHI	Hospitel: 1 Inpa 28a. Dete of Ir (Month, I	atient 2 Enjury Day Year) Injury - At honelc. (Specify)	ER/Outpatier 28b. Time of Injury	nderlying cause of the state of	26. Place of Other: 4 Nursiury at ork? Yes 2 N	24e. Wes perfect of Death (Check only sing Home 5 Res 28d. Describe o	Yes 2 No en eutopsy primed?  Yes 2 No one)  dence 6 Stort how injury occur  Street and Numi wn, State)	24b. Were autous available completion of death?  1	opsy findings prior to n of cause  2 No  Number,

State Registrar 31. Date filed (Month, Day, Year)

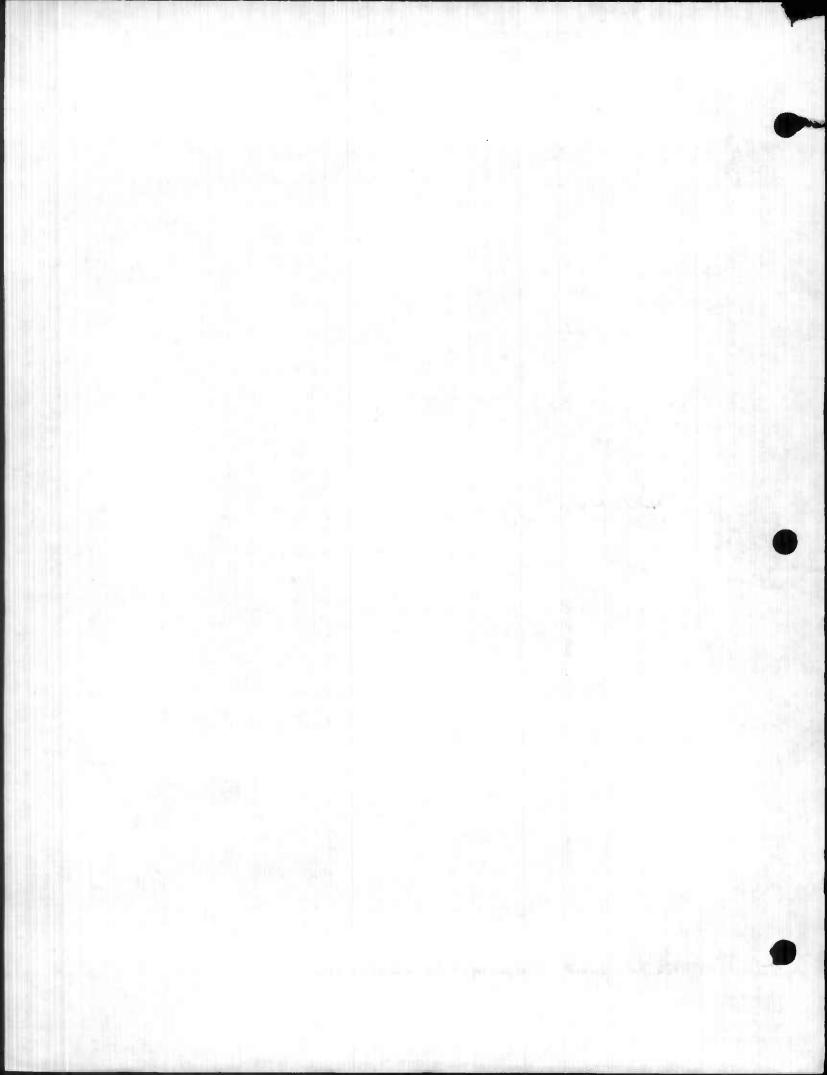
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32. Registrar's Signature

Sports



hysician			Cer	rtificate of L	Dealli		Reg. No.	
'hvsician	1. Decedent's Neme (First, Middle, Las	st)				2. Date of De	ath	3. Tima of Death
	EVELYN V.	YOUNKIN	S			Aug	Day	2000 11:15 PM
/Medical Examiner	4a Facility Name (If not institution, give				lb. City, Town, or	Location of Death	4c. County	of Death
	HOWARD COUL	ITY GENE	RAL H	tosp.	COLU	MBIA	10	WARD
uneral rector	5. Social Security Number 6. S 181-07-6955 1	ex	:. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Dete of Bir Month, Da Sept 2	2, Year)	9. Birthplace (State or Foreign Maryland
	Usual Residence of Decedent							
ahow Stat	10a. State 10b. County	10c. C	lity, Town or Lo	cation				10d. Inaide City Limit
recto	MD Howard		Marr	ciottsvil	le			1 ☐ Yes 2X N
r tems 23s or 25s-f si tres mant be nourse. Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country?
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	11. Meritel Stelus	12. Was Decedent Ever in Armed Forces?	U,S. 13. V	Was Decedent of H	ispanic Origin? (	Specify Yes or No	- 14. Race	e - American Indian, ck, White, etc.
b y	1 ☐ Never Married 2 ☐ Merried 3 ☒ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1□ Yes 2□ No			Specify	
t, the Medical	15. Decedent's Ed (Specify only highest gra		(Giva	dent's Usuai Occup kind of work dona o DO NOT usa ratired	dunina most of wo	orking	16b. Kind of Bu	usiness/Industry
d di	Elementery/Secondary (0-12)	College (1-4or 5+)			")		D	
Se Co	17. Father's Neme (First, Middle, Last)		ПС	omemaker	18 Mother's Na	ame (First, Middle)	Domes Maiden Sumem	
₽ <b>6</b>	Carlton Beac							
To metho		-	100 1100	- 144 (014		rence Boy		Conta Via Codal
treum	19a. Informant's Name/Relationship (1 Mrs. Gloria Fick			ng Address (Street a				MD 21104
ther the	20a. Method of Disposition			esition (Nama of	TIVEITUE	Date		City or Town, State
important: If Its any Injury or o once.	1 Donation 5 Other (Specify	Removal from State Chi	cemetary, cran	natory or other place he Brethrer	Cemetery	9/2/2000	Burkitt	tsville, MD
eny injury o	21. Signature of Funeral Service Licen			2. Name and Addres HAIGHT FU	NERAL HO	OME & CHA	APEL, P.A	. (Box 195)
			eth. Do not ente	Sykesvil	Le, MD	21784 (4	110) - 795 rrest.	-1400 Approximate
	23a. Pert1. Enter the disease, or comp shock, or heart feilure. List only	one caus deach line.						Interval Between Onset and Deeth
sician edical	Immediate Cause (Final	600	irada	- 12	of re-			d =
miner	disease or condition resulting in death)	a nesp	craio	ry fa	rocae			aays
- T	District of the last	Due to	(or as a conseq	luebte of):\/				down
min min		b. Preu.	nomo					- Carys
cian and burial-transit al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	(uence of):				
	Cause (Disease or injury that initiated events	c						
s the bu	resulting in death) Last	Due to	or es e consequ	uence of):				
usa as usa my		d						
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ched ched	Part ii. Other significant conditions of	ontributing to death but not re	sulting in the ur	nderlying cause giv	en in Pert I.		10	
detached detached	Part II. Other eignificant conditions of Uro Sep Sis,	extra py	esulting in the un	nderlying cause giv	en in Pert I.	23b. Dld	10	
signed by the ad be detached by Physical b	Part II. Other eignificant conditions of the sepsis,	extra py	esulting in the un	nderlying cause giv	en in Pert I.	ne 10	Yea 2000	3 Probably 4 Unknow
een signed by the incoming the detached hould be detached steep by Physical by	Mrosepsis,	extra py	rsulting in the ur	nderlying cause giv	en in Pert I.  yndrom	10 24e. Wes	10	3 Probably 4 Unknown  24b. Were autopsy findings evailable prior to
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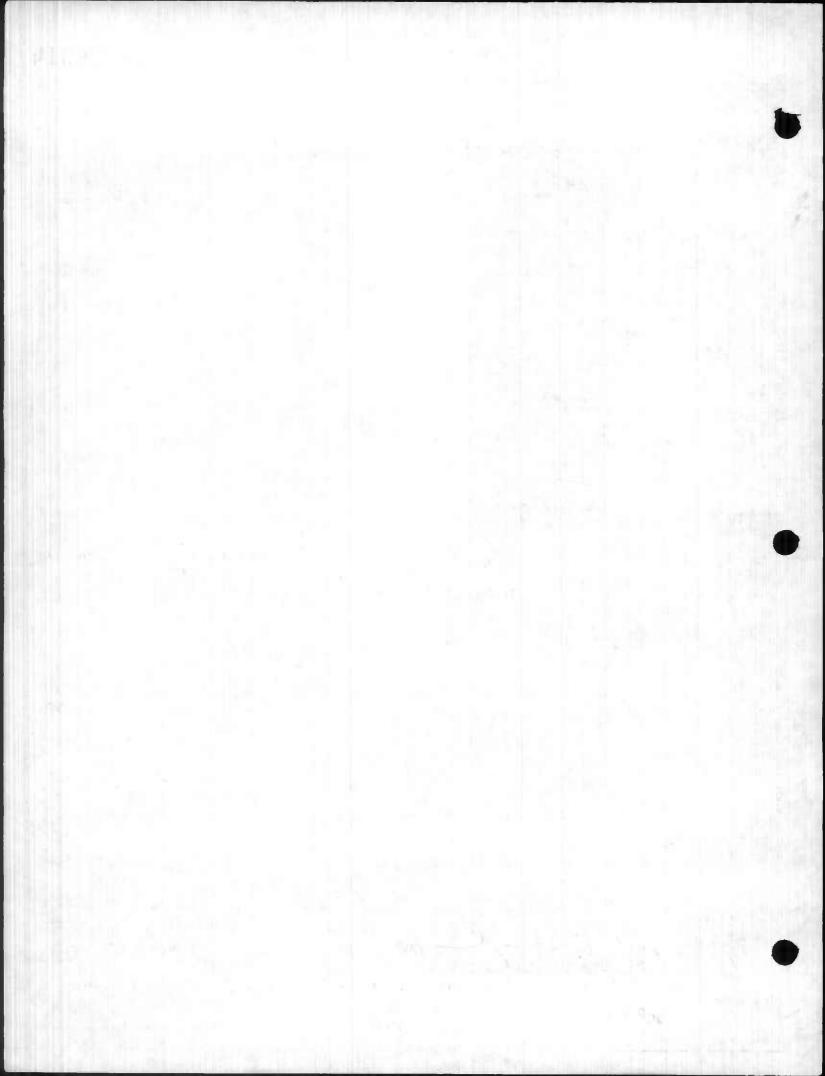


State of Maryland / Department of Health and Mental Hygiene 29314 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Dey **Physician** Joan Marie Alvie 6.20a.m. Deptember 15,2000 /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Healthcare Hanes If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-28-1944 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Days Hours 212-42-3642 Yrs. 55 MD Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show 1 ☐ Yes 2 No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Norne 23a or 905 Winsap Court 21227 U.S.A Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married 8 Baltimore, Maryland 21215-0020 White 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Par I Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Drywall Company 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be Mental Edna Hamilton Thomas Drury Jr. 19a. Interment's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an William Alvis / Husband 6235 Main Street Queenstown, MD 21658 Department of Health Important: If Item 27 20b. Place of Disposition (Name of cometery, crematory or other place)
Cemetery 20c. Location - City or Town, Stata 20a, Method of Disposition 1 Burial 2 Cremetion 3 Removal from Stete 4 Donation 5 Other (Specify) b 9-20-2000 Crownsville, MD MD Veterans 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signature of Funeral Service 1 Second Ave. S.W. Glen Burnie, MD 21061 23a. Part1, Enfau the disease, or shock of heart failure. Etal Approximate Intervel Between Onset and Death er complications that coused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, Physician Immediate Cause (Final disease or condition resulting in death) /Medical 3months Examiner Physician/Medical Examiner esions Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) The law requires that the deeth certificate be execut use as the burial-tran of Vitai Records, P.O. Box 68760, Due to (or as a consequence of): is certificate has been signed by the atte director, page 2 should be detached for 23h. Did tohacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Minknown þ 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? Be Completed After this certificate has 210 RIO 1 Yes 1 Yes 2 DATO 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 22No 2 ER/Outpetient 3 DOA Medical Certification: To filled in by the funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Attending 1 Neturel 2 Accident 5 Panding investigation death. 1 Yes 2 No Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide 6 To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29e. Certifier completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00053312 MID Systember 15, 2000 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Michelle Henggeleri mo Caton Avenue. Baltimore, mo 31. Date tiled (Month, Dey, Year) , 32. Registrar's Signature State 1 8 2000 SEP

Registrar

**DHMH 16 Rev 6/95** 

oaks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARNES SEPT. ENNET 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRESBU BALTIHORE STREET 8. Date of Birth (Month, Day, Year) NOV-13, 1923 If Under 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 12M 20 F Months Days 246-18-1230 Usuel Residence of Decedent Yrs. CAROLINA Director NORTH 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyslene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any july or orbor traumatic avant, the factor francism main be notified. 1 Nes 2 No Director MARYLAND 10e. Sireet and Number 10f. Zip Code 10g. Citizen of What Country? ESBURY STREET 12 Funeral 12. Was Decement Ever in U,S.
Armed Forces?
1 N Yes 2 No
If Yes, Give
Year or Detes: W W II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Merried 2 Merried 1□ Yes 2⊠ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 9 + HGRADE College (1-4or 5+) MPROVEMENT SELF-EMPLOVED 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ARNES OBERT DES1 2 ATTIE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Plece of Disposition (Name of cemetery, cremetory or other place) ADDINE BARNES BALTIMORE, MD, 2/2/6
20c. Location - City of Town, State PRESBURY ST. 20e. Method of Disposition Dete ₩Burial 2 Cremation 3 Removel from Stete 9-00 OWINGS MILLS, M.D. 4 ☐ Donetion 5 ☐ Other (Specify) FOREST GARRISON 21. Signalure of Funeral Service Licenses 22. Neme and Address of Fecility BROWN JR. FUNERAL HOME JOSEPH 2140 N. FULTON AVE. BALTO. MD. 212 23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart feilure. List only one cause on each line. Approximate Intervat Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Corcinoma Due to (or as a consequence of): the Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of): pue Box 68760. Physician/Medical Due to (or es a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.0. 3 Probably 4 Unknown 1⊠Yaa 2□No Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificata Division of Vital Hospital or Attanding Physician:
24 hours after death.
 Funeral Director: After this certifica 25. Wes case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29e. Certifier (Check only one) within 2 To the I 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9/4/2000 DW illiam Benedict, no 0008583

State Registrar

**DHMH 16 Ray 6/95** 

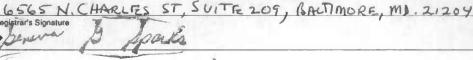
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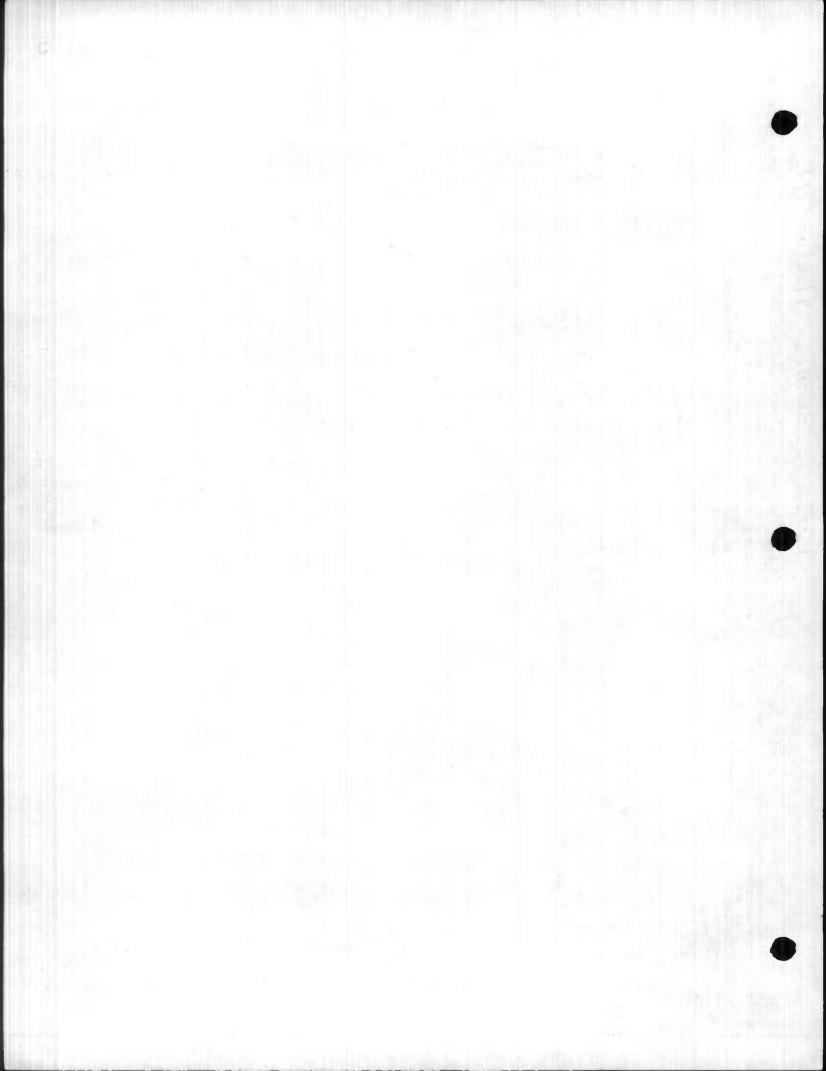
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31. Date filed (Month, Day, Year)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)







State of Maryland / Department of Health and Mental Hygiene

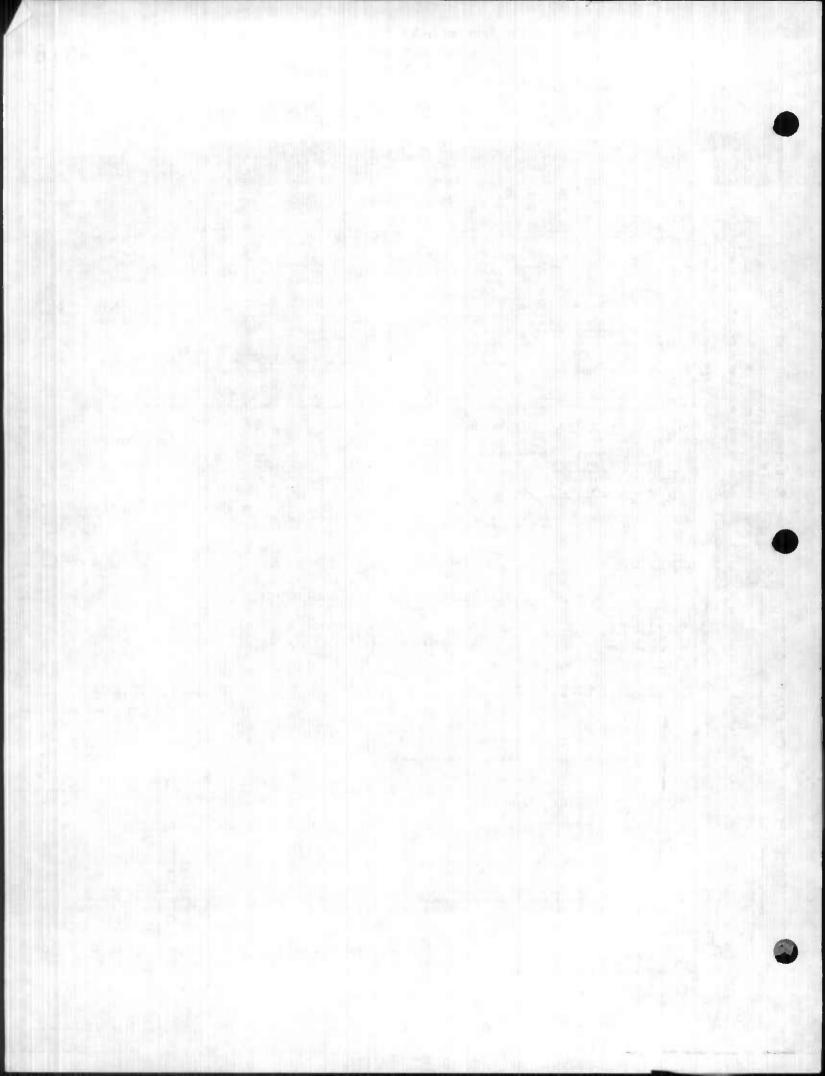
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** BURT HOMAS 4:59 PM SEPTEMBER 14 2000 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner MEMORIAL EMETE IMORE UNION If Under 1 Year Months Days 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. lest birthday) Hours 12 M 2□ F 217-40-532 Usual Residence of Decedent Director 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 □ No Director MARYLAND hygiene, other than "natural", or items 23s or 28e-vent, the Medical Examiner must be notifit 10e. Street and Number 10g. Citizen of What Country? 12 426 ON AVE. USA Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Maritat Status 1 Never Married 2 Merried 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1□ Yes 2No Specify: à 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) MD. CUP COMPANI 12 HAGRADE Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Mantal h and Mental 7 is marked o JAMES MARGUERITE WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 426 WINSTON AVE. Department of Health Important: If Nem 27 APTIO, BALTO, MD. 212 12 e 20c. Location - City or Town, State MARY BURTON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removal from State ö CEMEREN 9-20-00 BALTIHORE, HARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
JOSE PH H.
2140 N. FUL BROWN JR. FUNERAL HOME 21. Signature of Fundal Service Licenses 2140 N. FULTON AVE.

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart failure. List only one cause on each line. AVE. BALTIMORE, MD. 2/21 Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical SEPSIS Examiner Due to (or as a consequence of) Examiner FASGITI NECROTIZING The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Last Due to (or as a consequenca of): physician Box 68760 Physician/Medical Due to (or es a consequenca of): the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yss Division of Vital Records, Completed by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 2 No 2 NO No 1 ☐ Yes Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident after death Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide 8 2 To the Hospital or within 24 hours aft To the Funeral Dis completely fills, J in 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Yaulmwry MD SEPTEMBER 14, 2000 AT 2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE PKWY 21218 201 E. UNIVERSITY m WOLF. MD 31. Date filed (Month, Day, Year) SEP 1, 32. Registrar's Signeture State 1,8 2000 Daywood. Registra

DHMH 16 Rev 6/95



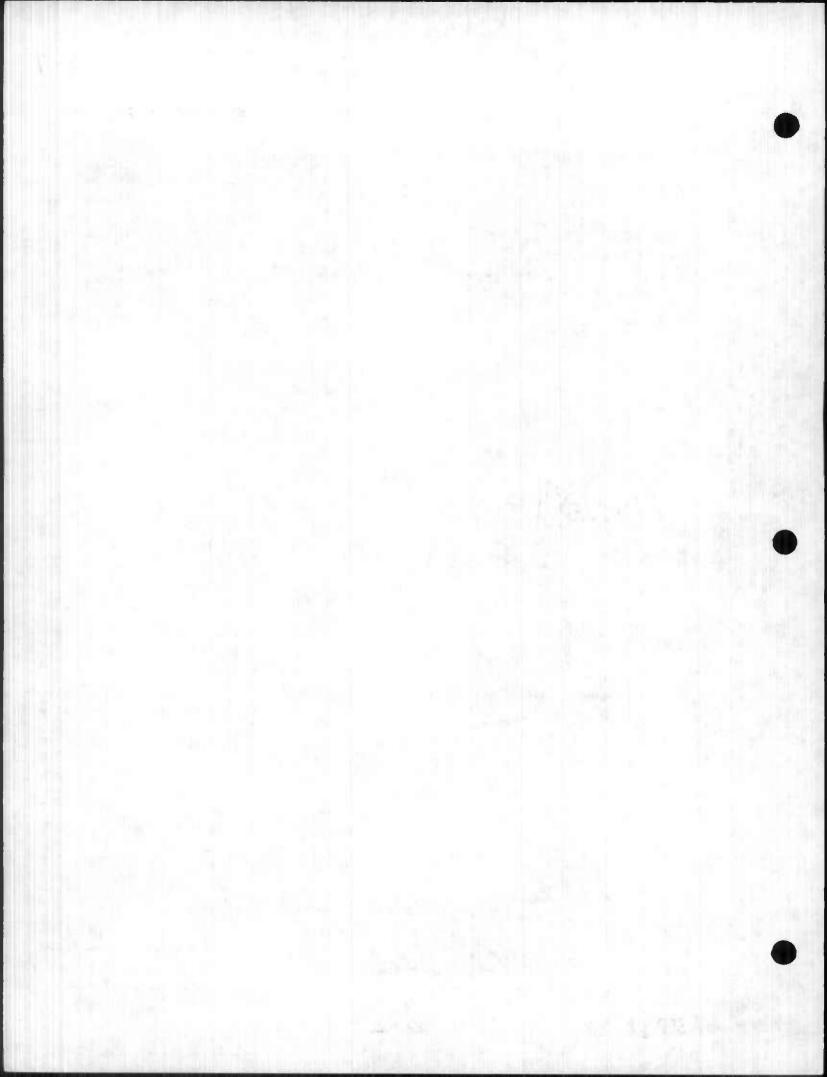
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Date of Death 3. Time of Death Day **Physician** KATHERINE BYRD SEPTEMBER 13, 2000 9:45 AM /Medical 4e Escility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5911 MEDORA DRIVE LINTHICUM ANNE ARUNDEL If Under 1 Yaar If Undar 24 Hrs. 5. Social Security Number 7, Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year) **Funeral** 1□M 2XF Days Hours 73 Yrs. Director 220-22-8804 AUG. 27, 1927 MARYLAND Usual Rasidence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No LINTHICUM 28a-f Directo MARYLAND ANNE ARUNDEL 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 8 21090 U.S.A. 5911 MEDORA DRIVE Herrie 23a Funeral 12. Wes Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puerto Ricen, etc.) 14. Race - Amarican Indian, Bleck, White, etc. 11. Marital Status 1 ☐ Yas 2 ☒ No If Yes, Give Yaar or Datas: 1 □ Never Merried 2 □ Merried Baltimore, Maryland 21215-0020 'natural', or 1 ☐ Yas 2 No Specify: WHITE ğ 3 ☑ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry Hygiene. Other than "n Elementary/Secondary (0-12) Collega (1-4or 5+) OWN HOME HOMEMAKER 12 permit. Pages 1 and 2 should be file.
Department of Health and Mental His important: if item 27 is merital His any Injury or other. 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) ENSHUTZ MARGARET STEINWIDLE HENRY 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) (DAUGHTER) 726 CHARINGTON ROAD, WESTMINSTER, MD. 21158 MRS. JANICE CHANEY 09/15/2000 Location - City or Town, Stata 20b. Placa of Disposition (Nema of camatary, crametory or other place) 20a. Mathod of Disposition Burial 2 Cremetion 3 Removel from Stata
4 Donation 5 Other (Specify) MARYLAND VETERANS CEMETERY CROWNSVILLE, MD. 22. Name and Addrass of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 MOIRAG ntartha diseasa, or complications that causad the death. Do not anter the mode of dying, such as cardiac or respiratory errest, heart daire. List only ond cause on each line. Onset and Deeth **Physician** Immediete Causa (Final disaasa or condition rasulting in daath) (Oligo dendrog lioma /Medical yrs Examiner Examiner certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Diseasa or Injury that infliated avants resulting in death) Last Bud Dua to (or as e consequance of) physician the burial 68760 Physician/Medical Dua to (or as a consequence of) Box 986 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco uss contribute to the cause of death? MN Serzur 1 Yas 2 No 3 Probably 4 Unknown Records, by 24b. Wara eutopsy findings evailabla prior to completion of causa of daath? 24a. Was en eutopsy performed? Be Completed page 1 Yas 20 No 1 ☐ Yas 2 ☐ No certificate of Vital 25. Was casa refarred to medical 28. Place of Death (Check only ona) Hospital: 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA Certification: To this 27. Mannar of Death 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1. Metural 5 Pending invastigation death. 1 Yas 2 No 2 Accidant Director: / 6 Could not be determined 3 ☐ SuicIda 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 28a. Plece of tnjury - At homa, farm, streat, tactory, office building, etc. (Specify) To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by 4 Homicida edicai Descripting Physician: To the best of my knowledge, deeth occurred at tha time, dete and piece, end dua to the cause(s) and manner as stated.

| Medical Examiner: On the best of axamination and/or invastigation, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) and manner stated. 29e. Cartifier (Check only one) 29b. Signature and title of certifian 29c. Licansa number 29d. Data signed (Month, Day, Year) 024356 goo Caton for Al 21229 30. Nama and addrass of person of death (Item 23s) (Type, Print) St Agnes Concer Center Waterfiel 31. Date filed (Month, Day, Year) 32 Registrar's Signatura State Registrar

DHMH 16 Rev 6/95

**ORIGINAL** 



Sta	ate of Maryland / Department of Health and N	lental Hygiene	00 0	20	12	1 (
	Certificate of Death	Reg. No.	00 2	. 7	0	10
Decedent's Neme (First, Middle, Last)		2. Dete of Death		3.	Time	of De

Physician	
/Medical	
Examiner	

**Funeral** 

or hams 23s or 28s-1 show the Medical Examiner must be notified at "natural". al Hygiene other than

the Many filed within 72 hours after

Saltimore, Maryland 21215-0020 Pages 1 and 2 should be nent of Health and Mental

operment of Health as important if Nem 27 is a any injury or other Physician /Medical **Examiner** The law requires that the death certificate be executed as the burial-tran and Box 68760. attending physician for use as the buria P.O. ate has been signed by the a page 2 should be detached of Vital Records. certificate has al or Attending Physician: To after death.

I Director: After this certificated in by the funeral director, pages. Division completely filled in by To the Hospital o within 24 hours at To the Funeral D

by

Be Completed

Certification: To

Medicai

29e. Certifier

(Check only one)

Month Day Year SEPTEMBER 13,2000 BROWN DAVID W. 4b. City, Town, or Location of Death 4e Facility Name (If not Institution, give street end number) 4c. County of Death N/A BALTIMORE GOOD SAMARITAN HOSPITAL Months Deys Hours Min. 8. Dete of Birth (Month), Day, Year) 964 6. Sex XXM 2□ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 5. Social Security Number 215-08-7897 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location BALTIMORE 10a. Stete 10b. County MD NA Director 10f. Zip Code 21215 10e. Street and Number 10g. Citizen of What Country? 5529 NOME AVE. USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Meritel Stetus 1X Never Married 2 ☐ Merried 1 Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Yeer or Detes Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry NA College (1-4or 5+) Elementary/Secondery (0-12) HOBERMAN PORT SERV MECHANIC 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) SHIRLEY CARTER JOSEPH N. BROWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 3906 GRANTLEY ROAD BALTO. MD 21215 19a. Informant's Neme/Relationship (Type, Print) SHIRLEY E. BROWN - MOTHER 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burlel 2XX remetion 3 ☐ Removet from State 4 ☐ Donetion 5 ☐ Other (Specify) 9/18/00 BALTIMORE, Md METRO CREMATORY 21. Signature of Funeral Service Licansee MARCH FUNERAL HOME WEST, INC. 4300 WABASH AVE. BALTO., Harris the reese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, the re. List only one cause on each line. Immediate Cause (Final disease or condition resulting in deeth) Pericardial Due to (or as a consequenca of) Examiner dissection Aortic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Lest Due to (or as e consequence of) Physician/Medicai Due to (or es a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Wes case referred to medical Y□ Yes 2□ No

27. Manner of Death 5 Pending investigation 1 Netural 2 Accident

3 Suicide 6 Could not be determined 4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Hospital: 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA

28b. Time of

29c. License number O.C.M.E.

28c. Injury at Work?

1 Yes 2 No

29d. Dete signed (Month, Day, Year) SEPTEMBER 13,2000

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

23b. Did tobacco use contribute to the cause of death? 1 Yes 22 No 3 Probably 4 Unknown

24e. Wes en eutopsy performed?

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

111 Penn Street, Baltimore, Maryland 21201

1 ¥ Yes 2 □ No

28d. Describe how injury occurred

01:27 A.M.

MD

21215

Approximate Interval Between Onset and Death

24b. Were autopsy findings available prior to completion of cause of death?

12 Yes 2 No

10d. Inside City Limits

WYes 2□No

MID Mys 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Radentz

Stephen S. R 31. Dete fled (Month, Day, Year) SEP 18 2000 State

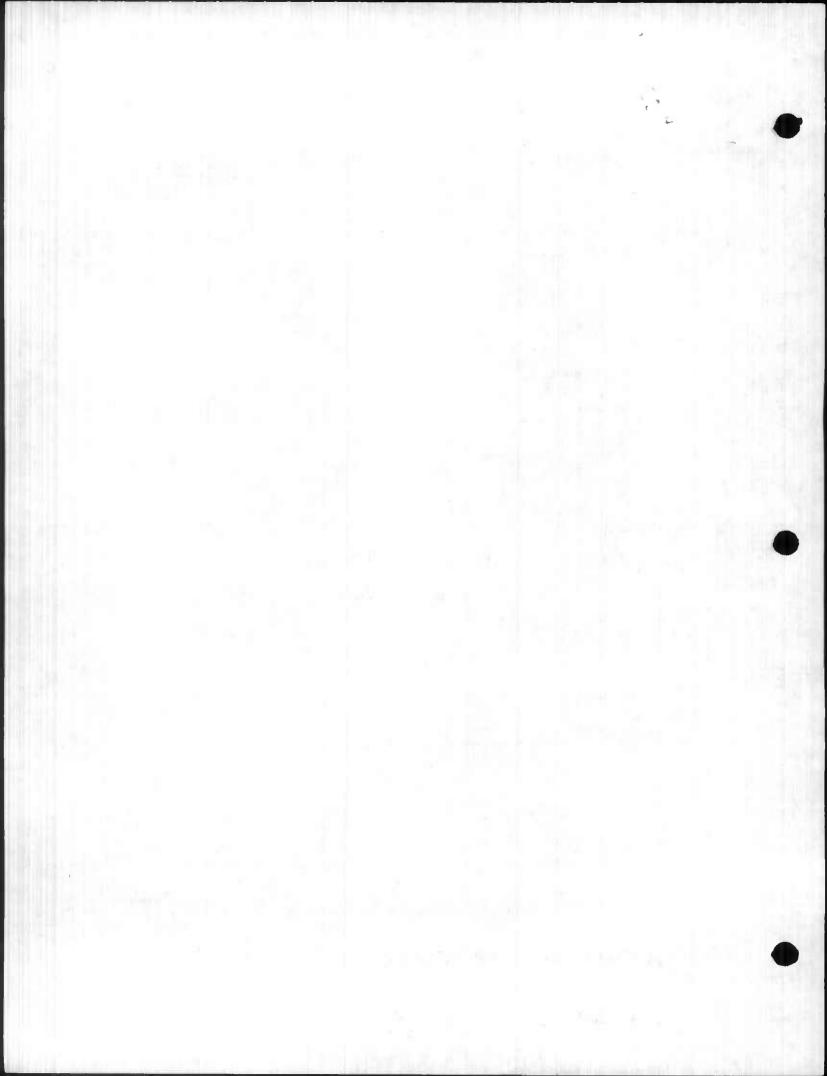
32. Registrer's Signeture

Lac

Sparks

**DHMH 16 Rev 6/95** 

Registrar



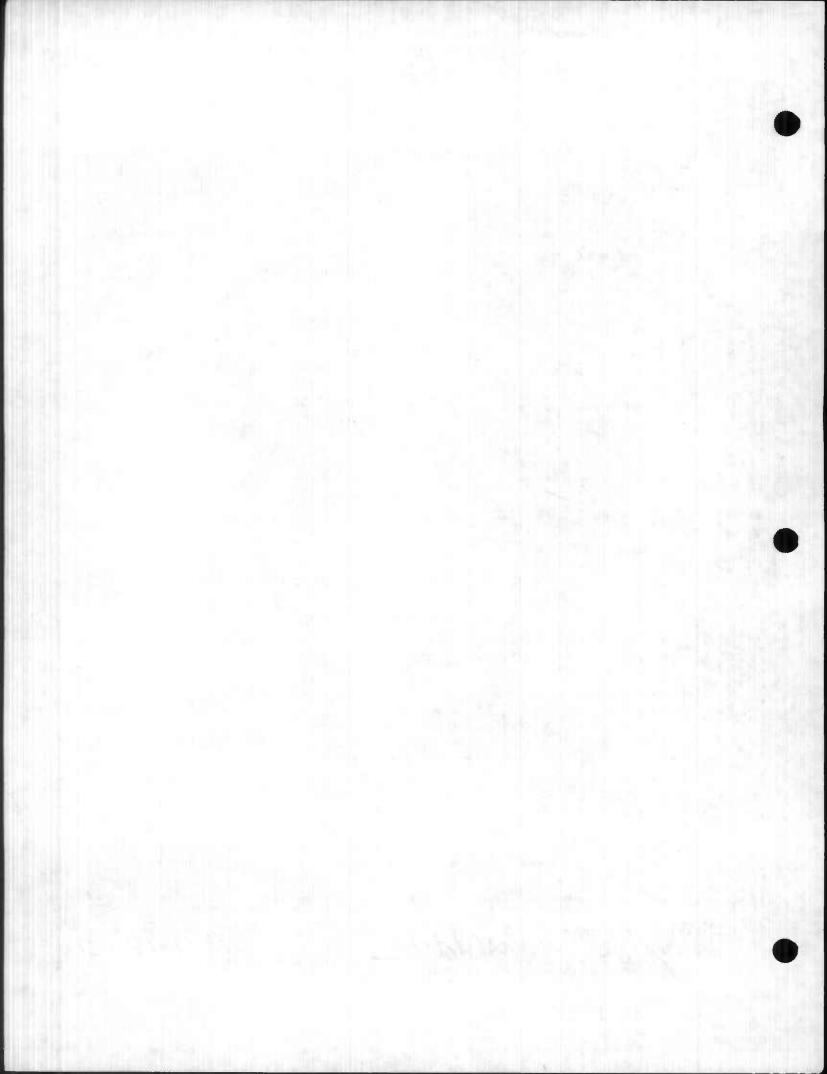
AMEND IT	EM: #11 PER F.H.		Department of F		Reg. N	le 00	29319
Physician /Medical	DONALD	BROWN			Month D SEPTEMBER	13/-	00 7:53 PM
Examiner	4a Facility Name (If not institution, give UNIVERSITY OF A			4b. City, Town, or Loca BALTIM ON		SALTIMO1	
Funeral Director	214-54-6995	X 7. Age (In yrs. last)	birthdey) If Under 1 Yeer Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Dey, Yee)	7) (	rthplace (State or Foreign Country) ryland
the Maryland 28a-f ahow cort ad at	Usuat Residence of Decedent  10a. State 10b. County  MD N/		wn or Location ALTIMORE				10d. Inside City Limits 1 X Yes 2 No
# 9 W	10e. Street and Number 1145 W. SARAT	OGA STREET	10f. Zip Code	21.223	10g. C	Citizen of What C	
urs after dea at, or hams by Funer	11. Marital Stetus  **Theorem Married 2   Married 3   Widowed 4   Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 200 No If Yes, Give Yeer or Detes:	13. Wes Decedent of H If Yes, specify Cub 1 ☐ Yes 2型 No	an, Mexican, Puerto Ri	ty Yes or No- can, etc.)	14. Rece - Arr Black, Wh Specify:	
d within 72 giene. In then "net".	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cettion 16 le completed) 16 Cottege (1-4or 5+)	Sa. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire PAPER FAC'	during most of working d)	7	Kind of Busines aterho Co.	s/Industry ffer Paper
Be aver	17. Father's Name (First, Middle, Last) Donald Brown,	Sr.	Take 1	18. Mother's Name (	First, Middle, Maide Harrin		
CENL	19a. Informant's Name/Relationship (7) Ethel Brown		9b. Mailing Address (Street 225 N. Cari				
odiffillore, omit. Pages 1 an Separtment of Heal montant: If Nem 2 ny Injury or other Mice.	20a. Method of Disposition  1 M Burial 2 Cremetion 3 F  4 Donation 5 Other (Specify)	Removel trom State Ceme	of Disposition (Neme of tery, cremetory or other ple Zion Cemet	ce)	Date 20c.	Location - City o	
permit. Pa Departmen Important: any Injury.	21. Signature of Funeral Service Licens	Suro DO	22. Neme and Address Howell 4600 Li	ss of Facility Wi Funeral berty He	11ie E. Home	2	1207
certificate be associed anding physician and use as the burial-transit	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. ACQUIRED Due to (or as	a consequence of):  (MMUNF a consequence of):	3 5 6	ency syn	UDROM E	
eath certific attending parties as	0 - 10 000 - 10 - 10 - 10 - 10 - 10 - 1	0.			On Didashas		to to the same of death?
bat the d by the detached	Part It. Other significant conditions con	ntributing to death but not resulting	g in the underlying couse gr	ven in Part I.	1 Yes		te to the cause of death? Probably 4 Unknown
Physician: The law requires that the death certificate has been signed by the attending rail director, page 2 should be detached for use at: To Be Completed by Physician/M.					24a. Wes an eu performed		Were autopsy tindings available prior to completion of ceuse of death?
certificate he rector, page		Castelli e		1.00		2. No	1 ☐ Yes 2 No
nysician: nis certific il director,	25. Was case reterred to medical examiner?  1 Yes 2 No	fospital: 1 Inpatient 2 ER/	Outpatient 3 DOA Ott	26. Place of Death ( her: 4 Nursing Home	(Check only one) e 5 Residence	6 ☐Other (Sp	pecify)
After fune	27. Manner of Death  1 Naturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Dey Year)		Yes 2 No	3d. Describe how in		Dural Davida Musikas
DIVISION STATEMENT OF ATTEMENT	4 Homicide determined	building, etc. (Specify)	farm, street, factory, office		City or Town, St	ete)	Rural Route Number,
12 FE 3		etclan: To the best of my knowled ner: On the basis of examination and manner stated.					
To the H within 24 240 the P complete	29b. Signeture and title of certifier,	1	29c. Licens	. 1	29d. I	Date signed (Mo	
. W.	Mellelle	dyy MD	1110	134	Seg	stember	13,2000
MN	30. Name and address of person who con FERNANDO A.	LOPEZ MD.	(Type, Print) 22 SOUT	H GREEN	E STRE	ET,	
State Registrar	SEP 1 2 20	32. Registrar's Signeture	4 1				

DHMH 16 Rev 6/95

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ORIGINAL

	Certificate of Death	R	eg. No.	2 3 3 2 0	
Physician	Decedent's Name (First, Middle, Last)	2. Data of Deal		3. Time of Death	
/Medical					
Examiner	Saint Joseph Medical Center Tow			Death altimore	
uneral rector	5. Social Security Number 215-12-4735  6. Sex 1		1924	Birthplace (State or Foreig Country)	
1	Usuat Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	1000		10d. fnside City Limit	
fied a	MD Baltimore Parkville			1 ☐ Yes 2 ☐ N	
be notified	10e. Street and Number 10f. Zip Code	1	0g. Citizen of Who	at Country?	
	9000 Chateaugay Court 21234		U.S.A.		
at, or thams 23s Examinar must by Funeral		(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White		
ated	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of w	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			
it, the Medical	Elementery/Secondery (0-12) College (1-4or 5+) // Mourement discontent		Railroad		
	11 yrs. Movement director 17. Father's Name (First, Middle, Last) 18. Mother's N	lame (First, Middle, I			
o Be	Diddies II	and the second			
T T	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or		r, City or Town, St	ate, Zip Code)	
1	Thelma H. Biddison-wife 9000 Chateaugay Court, Bal	timore, MD	21234		
7 2 2	20a. Method of Disposition  1  Buriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Oak Lawn Cemetery	9/19/00	20c. Location - Ci		
any in	21. Signature of Funaral Service Licensee William G. Dau  22. Name and Addrass of Facility L 5305 Harford Rd., Ba	eonard J. Ru 1timore MD		Home, Inc.	
ng physician end as the buriel-transit	Due to (or as a consequence of): CHRONIC OBSTRUCTIVE PULMONA  b.  Dua to (or as a consequence of): CONGESTIVE HEART FAILURE Couse, Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  CORONARY ARTERY DISEASE	RY DISEA	RSE		
for use	d.				
d by the etached	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.  RECENT CORONARY ARTERY BYPASS	1	23b. Did tobacco use contribute to the cause		
should be d	GASTROINTESTINAL BLEEDING	24a. Wes a perfor	an autopsy med?	24b. Were eutopsy findings available prior to completion of ceuse of death?	
r, page 2 should	VENTRICULAR TACHYCARDIA ATRIAL FIBRILLATION	1 D Y		1 □ Yes 2 ◯ No	
rector, par irector, par D Be Co	examinar?	Deeth (Check only or		/C	
eral dire	27. Menner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	Home 5 Resid	ow injury occurred		
To the Funeral Director: After it completely filled in by the funera Medical Certification:	Shatural   5   Pending   (Month, Day Year)   Injury   Work?	281. Location (S City or Tow	itreet and Number n, State)	or Rural Route Number,	
To the Funeral Direct completely filled in by Medical Certiff	29a. Cartifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, dete and plate (Check only one)  Check only one)	ace, end due to the occurred at the time, o	ause(s) and manr date and place, an	ner es stated. d due to the cause(s)	
To the complete of the complet	29b. Signature and title of certifies and glas Clarke D31476	2	29d. Date signed (	Month, Day, Year)	
7	and address of person who controlled cause of death (ttem 23a) (Type, Print)  ES DOUGLAS CLARKE M. D. 7601 OSLER DRIVE	TOWSON,	MARYLAN	ND 21204	
State	31. Date filed (Month, Day, Year)  SEP 1 2 2000  32. Begistrar's Signatura				



partment of Health and Menta	I Hygiene	00	2	0	2	2
ertificate of Death	Reg. No.	00	2	7	J	6

TYRONE	E BA	ARRETT	State of Marylar		artment of ertificate of		Mental Hy	rgiene ()	0 29	321
Dhur	inian	1. Decedent's Nama (First, Middle, Le		1855			2. Date of Do	eeth Day	3. T Year	ima of Death
	ician dical	14 RONE	BARRETT				SEPTEME			33 A.M.
	niner	4a Facility Name (If not institution, gir				4b. City, Town, or				
15		rear even side 31	~		If Under 1 Yea	BALTIMOR  r   If Under 24 Hrs		N/		***
Funei Direct			Sex 7. Age (In yrs. 11) Age (In yrs. 24	Yrs.	Months Days			ay, Year)		State or Foreign
M M		10a. State 10b. County	10c. Ci	ty, Town or L	ocation	Allega-			10d. In:	side City Limits
the Mar 28a-f st notified	Director	Mary los BAL  10e. Street and Number	TIMORE	AKB	UTUS  10f. Zip Code			10g. Citizen of V		⊋ <del>Ye</del> s 2□No
Sa or	Ö	4425 ALAN I	Drive			1225			514	
after death with the Maryla or thems 23a or 28a-f shot miner must be notified at	Funeral	11. Marital Status  Never Married 2 Married	12. Was Decedent Evar in L Armed Forcas? 1 Yes	,S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? (5 ban, Mexicen, Puer	Specify Yes or N to Rican, etc.)	o- 14. Rac	e - Americen Ind k, While, etc.	lian,
Exam.	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2- ☐ No	Specify:		Specify	Black	
72 hours returnif, fical Exp	pete	15. Decedent's E (Specify only highest gr	ducetion ade completed)	16a. Dece	edent's Usual Occu	upation e during most of wo	orkina	16b. Kind of Bu	usiness/Industry	
d within 72 hours at giens. If then "natural", or then "natural", or the Medical Exams	To Be Completed	Elementary/Secondary (0-12) 9 # 9 rade	College (1-4or 5+)	/ life.	DO NOT use retir	worke		mcG	JUDUST	ried
D STATE	98	t7. Father's Name (First, Middle, Last		OLI-III.				e, Maiden Surnam	10)	
y id hund the manual with a series	0	MILTON BARR	GTT, SR.				B. a			
Mctrylding  2 should be Ille  th and Mental Hy  7 is marked other  traumatic event		19a. Informant's Name/Relationship	(Type, Print)  MOTHER			et and Number or A				
C 5 N L	- 75	20a. Method of Disposition		Place of Disp	osition (Name of	00 1100	Date /	20c Location .	City or Town S	tata
Pages 1 a ment of Hea ant: If Nam		1 Burial 2 Cremation 3 4 Donation 5 Other (Speci	Removal from State	CBUTU.	Mematory or other pl	ress of Facility C	9/18/2	RUALBUT	us, ma	4/200
Departit Depart Import	9000	21. Signatura of Funaral Service Mos	nsee A	5	2. Name and Add 240 RE Balfingon	EISTERSW	MATHER.	- HARRE	s Frnera	Hone
		23a. Raft1. Enter the disease, or com shock, or heart feilure. List only	nplications that ceused the dea	th. Do not en	iter the mode of dy	ving, such as cerdia		arrest,	Appr	oximate vat Between
Physicia										et end Deeth
/Medic Examin	_	Immediate Cause (Finel disaasa or condition resulting in death)	MULTIPL	E 60	usitor (	Wounds			:	
ZAGITIII	- 0.0	resolding in death)		or es a conse					1	
nsit	Examiner	M. F. Lines	b						1	
icate be executed physician and sthe burial-transit	Exai	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying	Due to (	or as a conse	quence of):				1	
of ou,	dical	Causa (Disease or injury that initiated events	C. Due to /	or as a conse	ansuce of).					
death certificate be executed extending physician and of or use as the burial-transit	Pay	resulting In death) Last	1) 0) 960	n as a consor	quanto oi).					
th cert	Physician/M		d							
death be after bed for	SICI	Part II. Other eignificant conditions	contributing to death but not re-	sulting in the I	underlying cause (	given in Part I.	23b. Dlo	tobacco uee co	ntribute to the o	cause of death
es that the death certific igned by the attending p be detached for use as	by Phy			SIL.	a 5		10	Y00 2 NO	3 Probably	4 🗌 Unknow
requir been s should	Completed b						24a. Wa	s an autopsy formed?	availeble	on of ceuse
6 6 6	mo						1)(5	Yes 2□No	t) Yes	2 No
	Be C	25. Was case referred to medical				26. Place of De	eath (Check only			
- 5 0 0	0	examiner? 1X Yes 2 No		ER/Outpatie	INT BUILDUA	her: 4 Nursing	Home 5□ Res	sidence KIOth	er (Specify)SC	ENE
		27. Menner of Death  1 Neturel 5 Pending	28a. Date of Injury (144) (Month, Day Year)	28b. Time of	of (fund) 28c. Inj	ork?	28d. Describe	how injury occur	red	
Attending r death.	catic	2 Accident investigation	n 9110/00	12:30	) AM 11	Yes 2 No	5	UBJECT SH		
or Attendated after death	Certification:	3 Suicide 6 Could not be determined		fy)		0	28f. Location City or To	(Street and Numb	oer or Rural Rou	e Number,
Ned In				STILL				BALTIMOR	E, MD	
To the Hospital or within 24 hours afte To the Funeral Dire completely filled in	edical	29a, Certifier t Certifying Pl (Check only one) Medicai Exam	hysician: To the best of my knominer: On the basis of exemination and manner steted.	wiedge, deat ation and/or in	th occurred at the nvestigetion, in my	time, date and place opinion, death occ	e, and due to the surred et the time	e cause(s) and ma , date and place,	anner as etated and due to tha c	cause(s)
To the	Me	29b. Signatura and titla of certifiar				nse number		29d. Data signe	d (Month, Day,	Year)
1 0			1 1.1		00	ME		CEDUISA	DD 10 2	000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACK M. TITUS, M.D.
31. Date filed (Month, Day, Year) 32. Reg

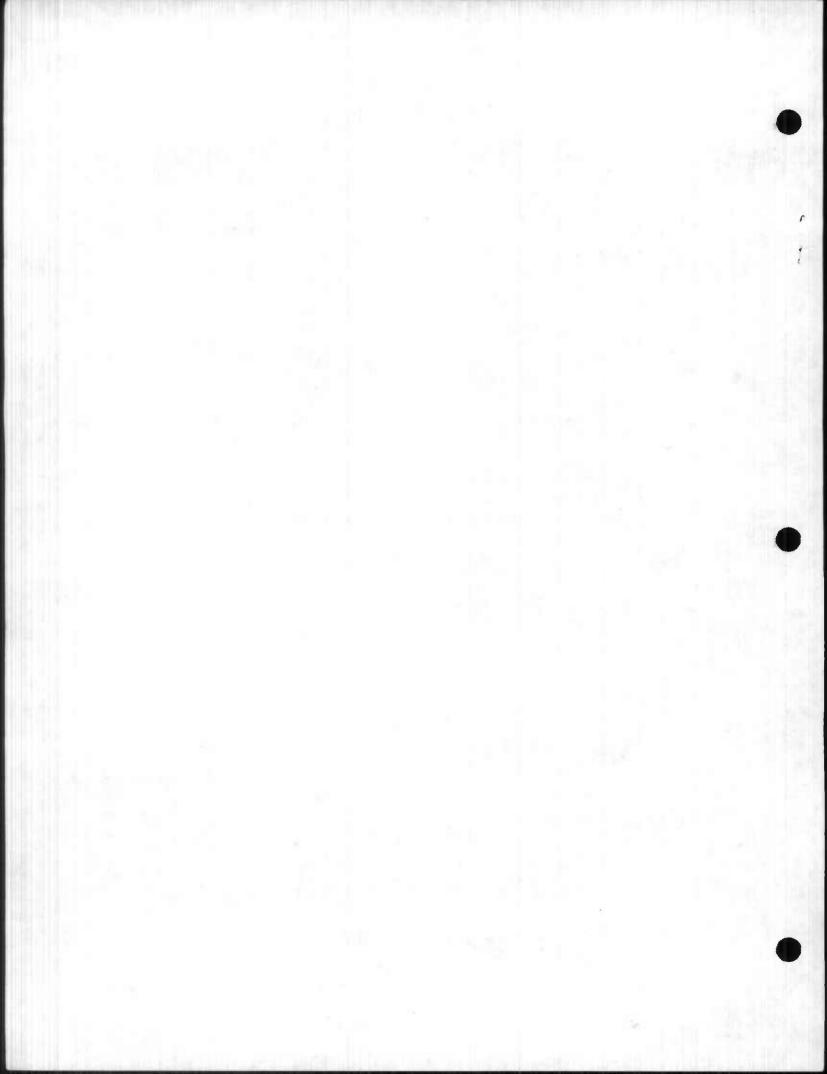
O.C.M.E. SEPTEMBER 10,2000

111 Penn Street, Baltimore, Maryland 21201

32. Registrar's Signature

**DHMH 16 Rev 6/95** 

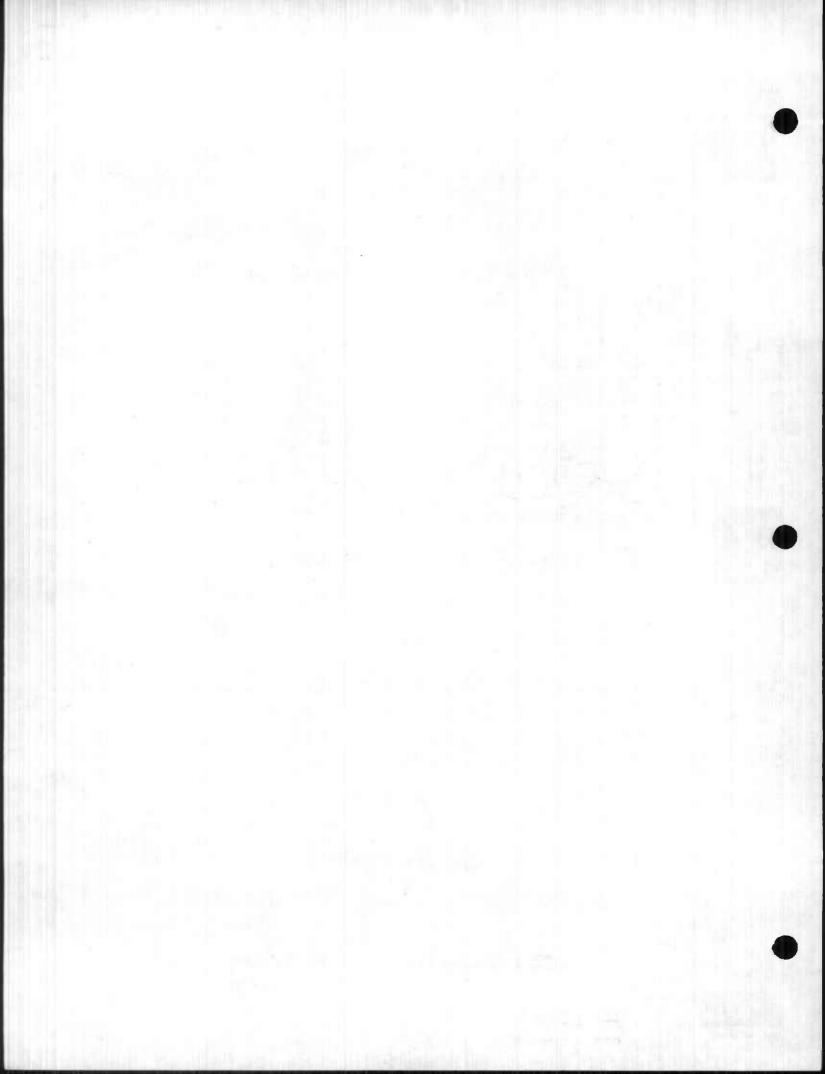
Registrar



		State of Maryland / Department of Health ar Certificate of Death	nd Mental Hygier Reg. I	00 23022		
	Physician	1. Decedent's Nama (First, Middle, Last)  JAMES M. CURTIS, JR.	2. Data of Death Month	Day Year 4:30 A.M.		
	/Medical Examiner		SEPT. 15	, 2000 4:30 A.M. 4c. County of Death		
	Funeral Director	5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24		ANNE ARUNDEL  9. Birthplace (State or Foreign Country) WASHINGTON, D.C		
	2	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits		
	Maryle 4 sho			1 ☐ Yes 2 ☒ No		
	vith the Ma	10e. Street and Number 10f. Zip Code	10g. (	Citizen of What Country?		
ith wit	23a o	678 QUAIL DRIVE 21061	Uì	NITED STATES		
020	72 hours after death with the Manyland natural", or flems 23s or 28s-f show oral Example must be notified at ested by Funeral Director	11. Marital Status  12. Was Decedent Evar in U,S. Armed Forces?  1 Never Married 2 Married  1 Yes, Sive Yaar or Datas:  13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, In Yes, Sive  1 Yes, Give Yaar or Datas:	n? (Specify Yas or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: WHITE		
21215-0020	E C	15. Decedent's Education (Specify only highest grada completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)  EQUIPMENT OPERATOR	of working	Kind of Business/Industry  STATE GOVERNMENT		
d 2	~ T = T	17. Fathar's Name (First, Middle, Last)  18. Mother's	s Name (First, Middle, Maid			
ylar	BARR C	JAMES M. CURTIS, SR. MARGA	RET EVELYN D	ICUS		
Maryland	and and and and and and	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number				
	1 an 1 deal 1 m 2 1 her	ANGELA C. CURTIS / WIFE 678 QUAIL DRIVE, GL  20a. Method of Disposition 20b. Place of Disposition (Name of		ARYLAND 21061  Location - City or Town, State		
		1K Burial 2 Cremation 3 Removal from State 4 Dorquion 5 Other (Specify)  Cemetery, crematory or other place)  GLEN HAVEN MEM. PARK	SEPT.18	EN BURNIE, MARYLAND		
Baltimore,	permit. Pages Department of Important: If it any injury or once.	21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility KIRKLEY-RUDDICK 421 CRAIN HWY.,	FUNERAL HOME,	, P.A.		
9	Physician	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line.	ardiac or respiratory arrest,	Approximate Interval Between Onset and Daath		
	/Medical Examiner	Immediate Cause (Final disaasa or condition resulting in death)  a. Renal Cell Carcinoma  Due to (or as a consequence of):  advanced an	locally	3 years		
	uted 3 ansit		d Metasta	ihe		
68760,	icate be executed physician and s the burial-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events				
Box 687	= = 0	resulting In death) Last  Due to (or as a consequence of):				
Ď.	death e atter ed for	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobec	co use contributa to the cause of death?		
<b>o</b> .	that the sed by the detacher	1   Yee 2   No				
Records,	aw requir		24a. Was an au performed			
	yelcien: The lav s certificate has director, page 2 To Be Comp	102 122	1□ Yes	2 No 1 □ Yes 2 No		
Vita	Sien:	axaminar/	of Death (Check only one)			
ō	5 00	1 Nast 2 No	sing Home 5  Residence 28d. Describe how in			
	Par in Par	1 Matural 5 Pending (Month, Day Year) Injury Work? 2 Accident 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
	To the Hospital within 24 hours To the Funeral completely filled Medical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	place, and due to the cause occurred at the time, date a	u(s) and manner as stated. and place, and due to the cause(s)		
	To the company of the	29b. Signature and title of certifier 29c. License number		Date signed (Month, Day, Year)		
	20	1 /1GC 0) 04297	9 51	EPT. 15, 2000		
	r Q	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Michael A. Carducci M.D. 600 N. Wolfest. 2	Balhowe M	02287		
	State Registrar	31. Date filed (Month, Day, Year)  SEP 1 8 2000  Separation  Separ				

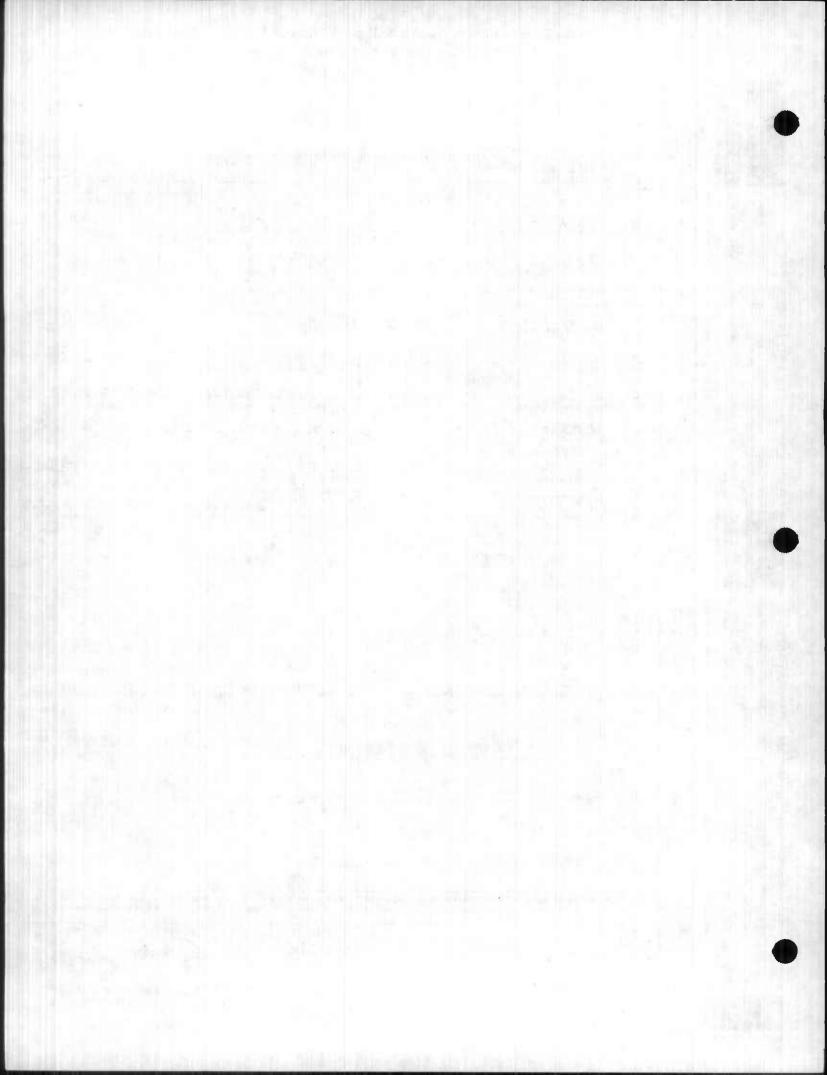
DHMH 16 Rev 6/95

**ORIGINAL** 



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Page, No. 29323

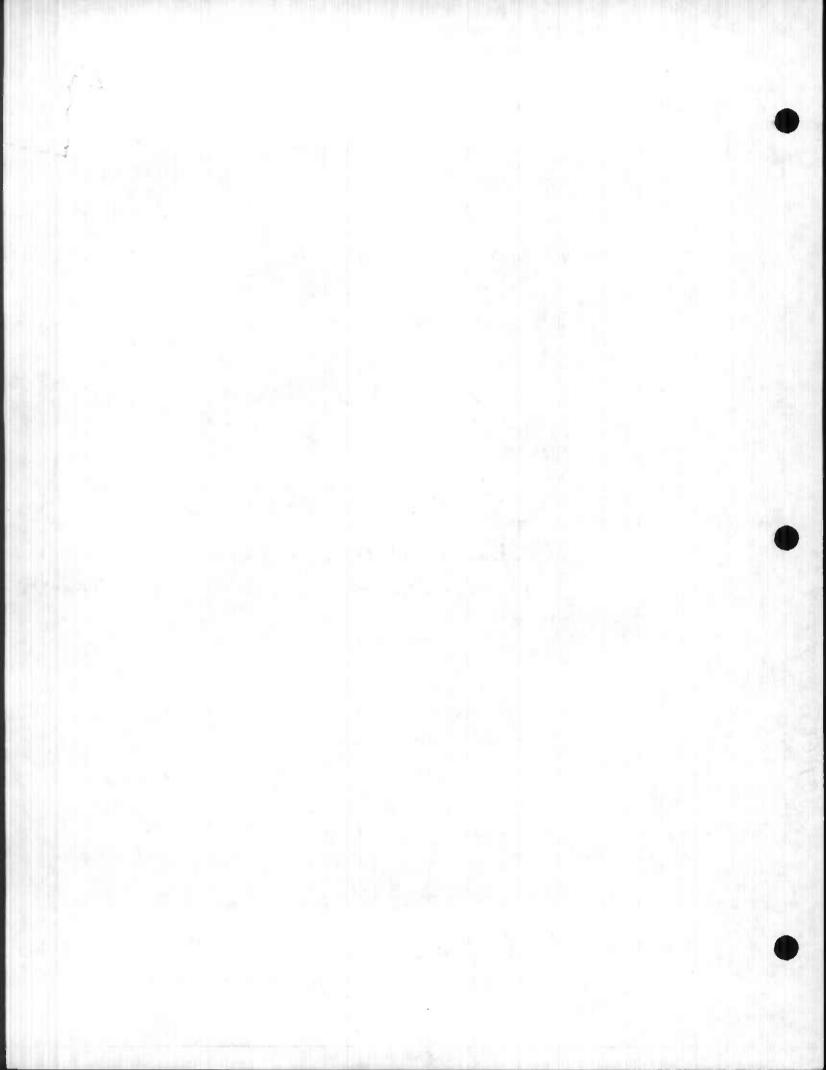
			Certificat	e of Death	Reg	. No.	27020	
	1. Decedent's Nama (First, Middla, L	ast)			2. Data of Death	100	3. Tima of Des	
Physician	Lillian			Solven ber	1 - 0 -	950 A		
/Medical Examiner	4a Facility Name (If not institution, gr	iva street end number)	111-1	4b. City, Town, o	r Location of Death	4c. County of	4	
LAGIIIIICI	1 lainocite of Mi	pryland Mean	1111524	ms Baltin	nord	N	A	
	5. Social Security Number / 6.	Sex 7. Age (In yrs., i	last birthday) If Unde	1 Year   If Undar 24 Hr	And the second s		Birthplaca (State or Fo	
uneral irector	122-32-0378		9 Yrs. Months	Days Hours Min	8. Date of Birth (Month, Dey, ) APRIL 3		JEW VORK	
iicotoi	Usual Residence of Decedent				MARIE	7771	EW YORK	
A W	10a. State 10b. County	10c. City	y, Town or Location				t0d. Inside City Li	
	MANULACIO A	1/4	13	ALTIMOR	c (1.71		16 Yas 2	
be notified Directo	MARYLAND A  10e. Street and Number	7771	10f. Zlg			. Citizen of Wha	at Country?	
		- n Air lui	101. 2.1	010	15			
r Name 23st diner mast Funeral	4911 LANI	ER MVENUE	NUE 2/2/5			cify Yes or No- 14. Race - American Inc		
un per	11. Marital Status	12. Was Decedent Ever in U, Armed Forces?	If Yes, spe	dent of Hispanic Origin? ( cify Cuban, Mexican, Pue	rto Rican, etc.)		White, etc.	
by F		If Yes, Give	1 ☐ Yes	2 No Specify:		Specify:	21000	
		Yaar or Dates:	10 0 0 11 11	10		Kind of Business	DEFICE	
t. the Medical Completed	15. Decedent's E (Specify only highest g		(Give kind of wo	al Occupation ork done during most of w se retired)	orking	6b. Kind of Busin	ness/industry	
E E	Elementary/Secondary (0-12)	College (1-4or 5+)				l	1-1-0-	
			SECH			INSUR	LANCE COM	
Be sed	17. Father's Neme (First, Middle, Las	11		18. Mothers N	ama (First, Middle, Mi	aiden Sumame)	1	
To To	VOSEPH	KA	UFMAN	CLAY	DEAN	KOL	BINSON	
	19a. Informant's Name/Reletionship		19b. Mailing Addres	(Street and Number of	Rural Route Number,	City or Town, St	ate, Zip Code)	
127 er tr	LAURA SMIT	TH (SISTER)	49111				MD. 212:	
ller off	20a. Method of Disposition	20b. P	Place of Disposition (Ne	ma of			ty or Town, State	
44	1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	LIRemoval from State	CTDAMA		10-11-10 0	BATTA	HORE MARYL	
11	21. Signature of Funeral Service Lice	1/6	22. Name a	nd Address of Facility	7-16 00 7	5 110111	TORE HANKY	
100		11/1/1		EPH H. R	BROWN	K. FUN	ERAL Hor	
	( uma	UE BAL	10. MD. 210					
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approx shock, or heart failure. List only one cause on each line.							
/sician		111	1/12/1				Onset and Dea	
ledical	Immediate Cause (Final disease or condition / Letras take BRPast CauseR						true VEHRE	
aminer	resulting in death)  Due to (or as a consequence of):							
in and fal-transit Examiner								
ician and burial-transit al Examír	Sequentially list conditions.	Due to (o	b. Due to (or as a consequence of):					
s the buria	Cause (Disease or injury that initiated events	r as a consequence of):	ce of):					
_ = _		resulting in death) Last						
use a	Towns In the second	d						
I for use			ntributing to death but not resulting in the underlying cause given in Part I.			23b. Did tobacco use contribute to the cause of		
the hed	Part II. Other significant conditions	contributing to death but not resu	ulting in the underlying					
Phy detail			1 Yes			2 2 No 3	Probably 4 Uni	
53 5					04-144		24b. Were autopsy findi	
_ = 0					24a. Was an perform		available prior to completion of caus	
oc oc							of death?	
as been si 2 should pleted							1 Yas 2 No	
8 W D					1 □ Yes	2 No		
8 N G	25. Was case referred to medical			26. Place of D	1 ☐ Yes		100	
certificate has rector, page 2 Be Comp	25. Was case referred to medical examiner?	Hospital: Monatient 2	ER/Outpatient 3 D	Other		)	(Specify)	
his certificate has il director, page 2 To Be Comp	25. Was case referred to medical examinar?	1) Inpatient 2L	ER/Outpatient 3 D	OA Other: 4 Nursing	eeth (Check only one	ca 6 Other		
funeral director, page 2 tlon: To Be Comp	25. Was case referred to medical examinar?	28a. Date of Injury (Month, Day Year)		Other	eeth (Check only one Home 5 Resider	ca 6 Other		
or: After this certificate has the funeral director, page 2 cation: To Be Comp	25. Was case referred to medical examinar?	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	OA Other: 4 Nursing 28c. Injury at Work? 1 Yes 2 No	Home 5 Resider 28d. Describe how	oca 6 Other vinjury occurred		
or: After this certificate has the funeral director, page 2 cation: To Be Comp	25. Was case referred to medical examinar?	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	OA Other: 4 Nursing 28c. Injury at Work? 1 Yes 2 No	eeth (Check only one Home 5 Resider 28d. Describe how	oca 6 Other vinjury occurred		
or: After this certificate has the funeral director, page 2 cation: To Be Comp	25. Was case referred to medical examinar?  1	28a. Date of Injury (Month, Day Year)  28e. Placa of Injury - At hobuilding, etc. (Specify	28b. Time of Injury M ome, farm, street, factory)	OA Other: 4 Nursing 28c. Injury at Work? 1 Yes 2 No y, office	Home 5 Resider 28d. Describe how 281. Localion (Str. City or Town,	oca 6 Other vinjury occurred set and Number Stete)	or Rural Route Number	
or: After this certificate has the funeral director, page 2 cation: To Be Comp	25. Was case referred to medical examinar?  1	28a. Date of Injury (Month, Day Year)  28e. Placa of Injury - At he building, etc. (Specify  Physician: To the best of my know arminer: On the basis of examinet	28b. Time of Injury M ome, farm, street, factor y) wledge, deeth occurred	OA Other: 4 Nursing 28c. Injury at Work? 1 Yes 2 No  y, office et the time, date end ple	Home 5 Resider  28d. Describe how  28f. Localion (Stractly or Town,	oca 6 Other vinjury occurred set and Number Stete)	or Rural Route Number	
or: After this certificate has the funeral director, page 2 cation: To Be Comp	25. Was case referred to medical examinar?  1	28a. Date of Injury (Month, Day Year)  28e. Placa of Injury - At he building, etc. (Specify)	28b. Time of Injury M  ome, farm, street, factor  wledge, deeth occurred tion and/or investigation	OA Other: 4 Nursing 28c. Injury at Work? 1 Yes 2 No y, office et the time, date end ple, in my opinion, death oc	Peeth (Check only one Home 5 Resider 28d. Describe how 28f. Location (Str. City or Town, ce, and due to the cal curred at the time, dat	oca 6 Other vinjury occurred set and Number Stete) use(s) and mann e and place, and	or Rural Route Number ler as stated. d due to the cause(s)	
Director: After this certificate has 1 in by the funeral director, page 2	25. Was case referred to medical examiner?  1	28a. Date of Injury (Month, Day Year)  28e. Placa of Injury - At he building, etc. (Specify  Physician: To the best of my know arminer: On the basis of examinet	28b. Time of Injury M  ome, farm, street, factor  wledge, deeth occurred tion and/or investigation	OA Other: 4 Nursing 28c. Injury at Work? 1 Yes 2 No  y, office et the time, date end ple	Peeth (Check only one Home 5 Resider 28d. Describe how 28f. Location (Str. City or Town, ce, and due to the cal curred at the time, dat	oca 6 Other vinjury occurred set and Number Stete) use(s) and mann e and place, and	or Rural Route Number,	
or: After this certificate has the funeral director, page 2 cation: To Be Comp	25. Was case referred to medical examinar?  1	28a. Date of Injury (Month, Day Year)  28e. Placa of Injury - At he building, etc. (Specify  Physician: To the best of my know arminer: On the basis of examinet	28b. Time of Injury M  ome, farm, street, factor  wledge, deeth occurred tion and/or investigation	OA Other: 4 Nursing 28c. Injury at Work? 1 Yes 2 No y, office et the time, date end ple, in my opinion, death oc	Peeth (Check only one Home 5 Resider 28d. Describe how 28f. Location (Str. City or Town, ce, and due to the cal curred at the time, dat	oca 6 Other vinjury occurred set and Number Stete) use(s) and mann e and place, and	or Rural Route Number ler as stated. d due to the cause(s)	
or: After this certificate has the funeral director, page 2 cation: To Be Comp	25. Was case referred to medical examinar?  1	28a. Date of Injury (Month, Day Year)  28a. Placa of Injury - At he building, etc. (Specif)  Physician: To the best of my known aminer: On the basis of examinet and manner stated.	28b. Time of Injury M  ome, farm, street, factor  wledge, deeth occurred tion and/or investigation	OA Other: 4 Nursing 28c. Injury at Work? 1 Yes 2 No y, office et the time, date end ple, in my opinion, death oc	Peeth (Check only one Home 5 Resider 28d. Describe how 28f. Location (Str. City or Town, ce, and due to the cal curred at the time, dat	oca 6 Other vinjury occurred set and Number Stete) use(s) and mann e and place, and	or Rural Route Number, ler as stated. d due to the cause(s)	



State of Maryland / Department of Health and Mental Hygiene 00 29324

		Certificate of Death Reg. No.							
	. Decedent's Name (First, Middle, La	sf)				2. Date of Death Month	Day '	Year	3. Time of Death
an al	LINDA	IRENE		CAGE	R	SEPTEMBE	R 09,	2000	2342
al er <sup>46</sup>	Facility Neme (If not institution, giv	e streef and number)			4b. City, Town, or	ocation of Death	4c. County of	Death	7317
_	ST. AGNES	HOSPITAL	_	A 140	BALTI	MORE	N	IA	
5.		ex 7. Age (In yrs.	last birthda	y) If Under 1 Yee		8. Date of Birth (Month, Dey, )	(and	9. Birthpi	ace (State or Fore
-	212-70-3343 1 Isual Residence of Decedent	OM 25/8 44	Yrs.	Months Dey	s Hours Min.	SEPTEMBER	110,1955	MAR	RYLAND
10	0a. State 10b. County	10c. City	, Town or	Location				10	Od. Inside City Lim
5 /	MARYLAND ANNE AF	RUNDEL PF	13A	AUBO					1 2 Yes 2 1
	0e. Streef and Number			10f. Zip Code		100	. Citizen of Wh	hat Coun	try?
1	7860 Shirley	Murphy Ct.		2 211			U.S.	A.	
1	1. Marital Status	12. Was Decedent Ever in U, Armed Forces?	S. 13	<ol><li>Was Decedent of If Yes, specify Cu</li></ol>	Hispanic Orlgin? (S ban, Mexican, Puer	pecify Yes or No- o Rican, etc.)	14. Raca Black	- America , White, o	
24	1 Never Merried 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1□ Yes 2 No	Specify:		Specify:	BU	ACK
	15. Decedent's Ed		16a. Dec	cedent's Usual Occi	upation	ting 16	bb. Kind of Bus	iness/Inc	lustry UNKNO
-	(Specify only highest gra	College (1-4or 5+)	life	DO NOT use retir	e during most of wored)	King	1101	V	
1	ITH GRADE	Comage (1 401 01)	D	OMEST	ic Wor	RKER	UIV	1	
1	7. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, Me	siden Sumame	)	
3	JUSHRA		CAC	SER	CATHER	SINIS	SF	MUF	DERS
-	9a. Informant's Neme/Relationship (					ural Route Number,			
		WER (SISTER)							
				position (Name of	DR., GLE	Date 20	Oc. Location - C		
2	0a. Method of Disposition  1    Buriel 2 □ Cremetion 3 □	Demoval from State	emetery, cr	rematory or other p					
. 1	4 ☐ Donetion 5 ☐ Other (Specif	N) MT.	ZION	U.M.C.C	EMETERY	09-15-00 PA	BADE	VA)1.	MARYLA
2	1. Signeture of Funeral Service Licer	1599		22. Name end Add	ress of Facility	4			
	10-15	1./11.//				W JR. FO			
	The second of	V. Var				E, BALTI		110	
-	23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.	n. Do not e	enter the mode of o	ying, such es cardie	or respiratory arres	Л,	!	Approximete Intervat Between
				1 . 1				1	Onset and Deet
d	mmediate Cause (Finat disease or condition	. Intracro	wide	il He,	125000	rage			3 wee
- 1	esulting in death)	Due to (o	r as a cons	sequence of):				1	
		Hyperots	100	70-u					Ymon!
C Asminer	Sequentially list conditions	Due to (o	ras a cons	equenca of):					
Y if	sequentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or Injury							i	
E C	Cause (Disease or Injury hat initiated events	C. Due to to		equence of):				-	
edicai	esulting in death) Last	D0 10 (0	as a cons	equence or,					
2									
Physician									7-11-11
P	ert II. Other significant conditions c	ontributing to death but nof res	ulting in the	underlying cause	given in Part I.	23b. Dld tob	acco use conf	iribute to	the cause of de
5						1 Ve	2 00 No	No 3 Probably 4 Unkn	
- 6									
8						24a. Was an	autopsy ed?	\$V	are autopsy findir
Completed						periorite		COI	mpletion of cause death?
E						457			
						1 Ves		11	]Yas 2□ No
3	<ol><li>Wes case referred to medical axaminer?</li></ol>	Hospital:				ath (Check only one	)		
2	1 Yes 2 No			ient 3LI DUA		lome 5 Residen			y)
Certification	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury Work?				ury at ork?	28d. Describe how	v injury occurre	id	
3	2 Accident investigation M 1			Yes 2 No					
2	3 Suicide 6 Could not be determined	288. Piece of injury - At no					28f. Location (Street end Number or Rural Route Number,		
	- Chomicide	building, etc. (Specifi	7)			City or Town,	Siele)		
2	9a. Certifier 1 X Certifying Ph	ysician: To the best of my kno	wlerke de	ally occurred at the	time dete and also	and due to the car	isa(s) and may	2001	ated
2		niner: On the basis of examine	tion and/or	investigation, in my	opinion, deeth occu	rred et the time, det	e and pleca, a	nd due to	the cause(s)
	10	and manner stated.		00-12-	and number	1.00	d Data size d	March	Day Vacat
2	9b. Signeture and title of dertillor	/ /		29c. Lice	nse number	29	d. Date signed	(Month,	Day, Tear)
	MITAL	lupy	UN	0	27319	Hospi	erden	her	10,20
30	0. Name and address of person who	completed cause of death (Item	23a) (Typ	e, Print)			1,		1 -
	M / FC.	vale won	0 411	sd.	Apric	HOSDI	001		
2	1. Date fited (Month, Day 1995)	32 Shanishanda d	hum.	201	11	1			
3	SEP 1	8 2000 - 5A	wer	B	Day Fo				
ar	-	700		100	per a carried				

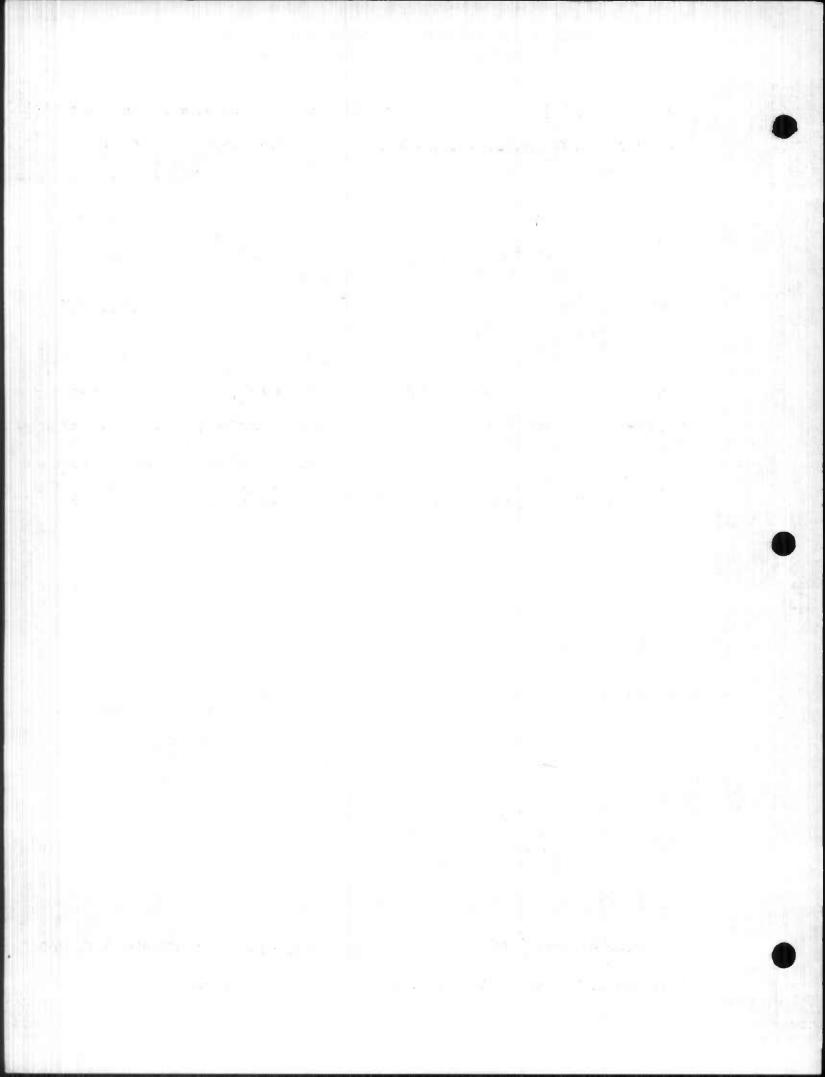
CAGER, LENDA



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death Month Day Year

					ate of Death	R	eg. No.	0 25	1325
Physici	an	1. Decedent's Nama (First, Middle, Li	ist)	0.1.		2. Data of Dea Month	Day	Year	. Tima of Death
/Medi		CHARITI		CHIL	DERS	seftembe	R 12 5	1 6000	1:50 AM
Examir	er	4a. Facility Name (If not institution, gi				r Location of Death	4c. County	of Death	
			ORIAL HO	OSPITAL		THORE		NIA	
Funeral Director			Sax 7. Aga (In 1	yrs. (ast birthday) If Ur 85 Yrs. Mont	ndar 1 Yaar If Undar 24 Hr hs Days Hours Mir		Year) 4,1915	9. Birthplace Country) Sout	
H show		10a. Stata 10b. County	100	. City, Town or Location				10d.	Inside City Limits
28a-f sho	ctor	MARVLAND N.	A	BA	LTIMORE	CITY			1/K Yes 2□No
or 20	Funeral Director	10e. Street and Number	. 14	10f.	Zip Code		0g. Citizan of \	What Country?	
238	la	11 WEST 2	OTHST, AT	TAB	212	18	U:	SA	
items 23.	Jue	11. Marital Status	12. Was Decedent Evar Armed Forces?	in U,S. 13. Was De	ecedent of Hispanic Origin? ( specify Cuban, Maxican, Pus	(Specify Yes or No- arto Rican, atc.)		e - Amarican (ck, White, atc.	
8	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Datas:		s 2 No Specify:		Specify		ax
"natural", or He	Completed	15. Decedent's E	ducation	16a. Decedent's U	Isual Occupation	CHARLE TO THE STATE OF THE STAT	16b. Kind of B	usiness/Indust	iry
- 4	pie	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	work done during most of w Tuse retired)	rorking			
giene Fr the	Om	Elementary Court (C 12)	ZVRS	PR	ESSER		FISH	- LAU	NORIL
other vent, ti	Bec	17. Father's Name (First, Middle, Las	) [		18. Mother's No	ame (First, Middle,			
I Health and Mental Hyg tem 27 le marked othe other traumetic event,	TOE	WILLIE	FEL	DER	ANNI	E	M	11.LE	R
end N		19a. Informant's Name/Reletionship	(Type, Print)	19b. Malling Add	ress (Street and Number or I	Rural Route Numbe	r, City or Town,	State, Zip Co	de)
27 l		WILLIE CHILDE	RS (SON)	2570	W. FAIRMOU	NT AVE	BALI	IMPRE	MD. 212
		20a. Method of Disposition	20	b. Place of Disposition (	Nama of		20c. Location -		
= 0		12 Burial 2 □ Cremetion 3 [ 4 □ Donetlon 5 □ Other (Speci		UTZION	CEMETERY	9-16-00	1 ANSO	MULKE N	UARVIAND
Department of Important: If any Injury or phose.		21. Signature of Funeral Service Lice	risee a	22. Name	e and Address of Facility	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	TO 51	WERD!	Honer
Depa impo		Vinland	11,111	Jos	e and Address of Facility B	ROWN	DA. FU	NEKAL	2 4 .7
_		23a Part 1 Foter the disease or con	polications that caused the	teeth. Do not enter the	TO N. I-ULTO	NAVE.	BALTE		oproximate
		23a. Part1. Enter the disaasa, or con shock, or heart fallure. List only	one cause on each line.	Joseff. Do not enter gran	noda or dying, such as cardi	ac or raspiratory air	eat,	Int	erval Between
ysician Medical		fmmediate Cause (Finel						1 1	5 11×10×
aminer		disease or condition resulting in death)	a. MASSIVI	E RIGHT C	EREBRAL I	ENFARCT	TIDIN	12	SHOURS
	-			to (or as a consequence				1.718	1411105
nsit.	Examiner		b. ACUTE			RCTION		46	8 HOURS
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physician and s the bunal-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C						
g phys	edicai	resulting in death) Last	Due	o (or as a consequence	of):				
ding se a	75		d						
for u	Physician/N								
the bed	ysi	Part II. Other algnificant conditions	contributing to death but not	resulting in the underlylr	ng cause given in Part I.	23b. Dld to	obacco use co	ntributa to the	e cause of death?
deta deta						1 🗆 Y	es 2 No	3 Probab	ly 4 Unknow
been signed by the attendin should be detached for use	1 by					The Miles	and the later	D4h Minn	nudanau štadinau
houl	Completed					24a. Was a perfor		avalial	autopsy findings ble prior to letion of cause
12 CI	npi							of dea	th?
pag	S					1 🗆 Y	es 2 No	1 🗆 Y	es 20 No
is certificata has director, page 2	Be	25. Was case referred to medical examiner?				eath (Check only or	ne)		
en 10	2	1 ☐ Yes 20 No	Hospital: Impatient	2 ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Raside	ence 6 Oth	ner (Specify)	
ther the		27. Manner of Death  1 Natural 5 Panding	26a. Data of Injury (Month, Day Yea	28b. Time of Injury	28c. Injury at Work?	28d. Dascribe h	ow Injury occur	red	
or: A	ati	2 Accident Investigation	n	М	1 ☐ Yes 2 ☐ No				
by t	Ĕ	3 Suicide 6 Could not be determined		At home, farm, street, fac	ctory, office	28f. Location (S City or Town		ber or Rural Ro	outa Number,
within 24 hours arer deam.  To the Funeral Director: After this completaly filled in by the funeral	al Certification:	29a. Certifying Pl	nyalcian: To the best of my	knowledge, death occurr	red at the time, dete and place	ca, and due to the c	ause(s) and ma	anner as state	d.
e Fu	edical	(Check only 2 Medical Example)	miner: On the basis of exar and mannar stated.	nination and/or investigat	tion, In my oplnion, death occ	curred at tha time, d	lata and place,	and due to the	cause(s)
Tota	×	29b. Signature and title of certifiar			29c. License number	2	9d. Data signe	d (Month, Day	, Year)
(		1 Vaulmu	all mo		AT 243894	16	EFTEN	BER 1	2,2000
		30. Name and address of person who		(Itam 23a) (Time Brint)	711 00 100 11	-			-/
1		0	MD 201		RSITY PKWY	1 01010			
		31. Date filed (Month, Day, Year)	32. Registrar'a S		TROOT	1 TIVIS			
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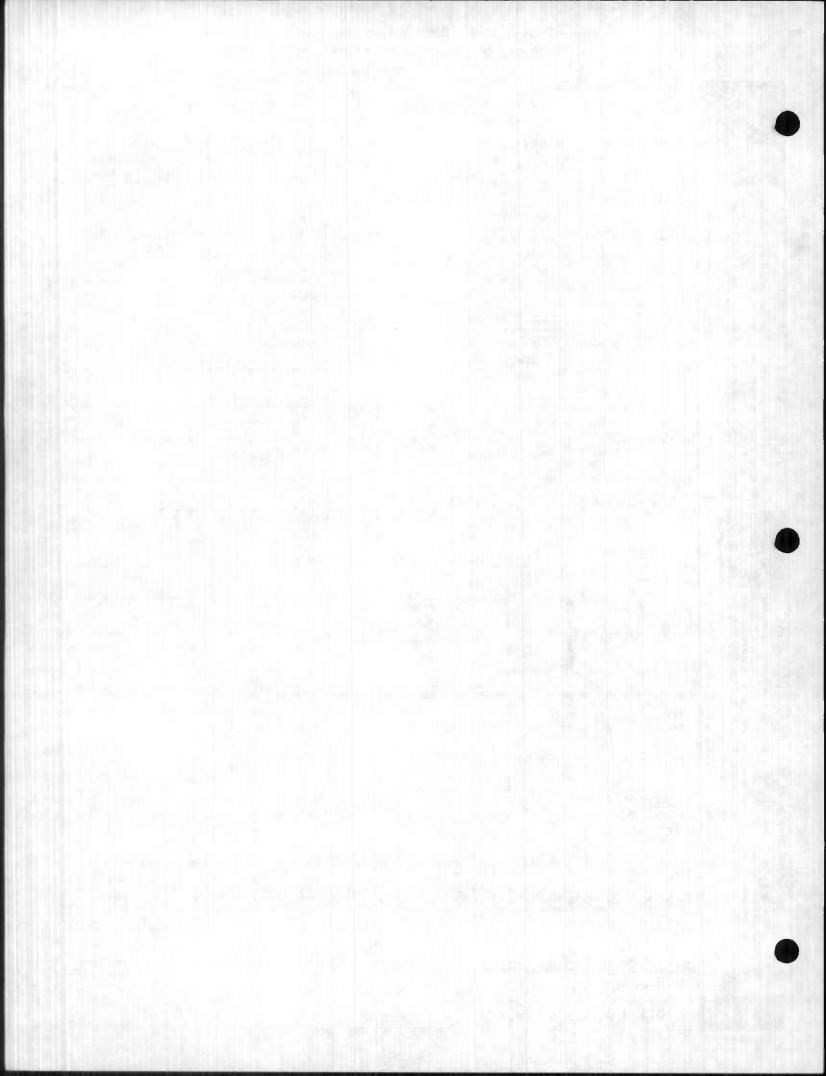
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		orate or maryra		Certifica	te of	Death	Worker 11	Reg. No.	0 2	29326
Physician	1. Decedent's Name (First, Middle, La		L-AA	A A İ			2. Date of D Month	Day	Year	3. Time of Death
/Medical	4a Facility Neme (If not Institution, giv		LEM	AN		4b. City, Town, or	r Location of Dea		of Death	11,00 M N
Examiner	A. A. A.		EDIC	AL SY	TEM	BALTIN	JOR I	NI	A	
Funeral Director	5. Social Security Number 6. S		s. last birtl		er 1 Yeer	If Under 24 Hr. Houra Mir	(Month, D			laca (State or Foreig
8 11	10a. State 10b. County			or Location					1	0d. tnside City Limits
med and	MD	I/A		BALTIM	ORE					1 Nes 2 No
here 23e or 28e-f showner must be notified at	10e. Street and Number 316 S. POPPLETON	ST.				230		10g. Citizen of V USA	1	
by By	11. Merital Statua  1 Never Merried 2 Merried  3 NWidowed 4 Divorced	12. Waa Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:	U,S.		edent of F pecify Cub 2 X No	Hispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or N irto Rican, etc.)	o- t4. Rac Biad Specify	a - Americ ck, White, BI	
dicel	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a.	Decedent's Us (Give kind of v	ual Occup	pation during most of wi	orking	16b. Kind of B	usiness/Inc	lustry
ypiene. er than "natura, t, the Medical. Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		HOUSE				HOS	PITAI	
	17. Father's Name (First, Middle, Last,	1		HOODE			ame (First, Middl	e, Meiden Suman		
ked off fic ever o Be	EZEKIEL MICHAEL						PENSLA C	ORBETT		
aith and M 27 is mer ir traumat	19a. Intormant's Name/Relationship ( PENSLA CORBETT/I		19b.					ber, City or Town,		
nent of He nt: If Nam ry or othe	20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	cemetery	Disposition (A v, cremetory of MEM PA	other ple		Dete 9/21/200	20c. Location -		
Departr Imports eny inji	21 Semature of Funeral Service Licer	Whata	n eth. Do n	JAMES	A. 1	MORTON & ENS ST			217	Approximate Interval Between
physician and secured as the buriel-transit	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	(or as a c	EAST onsequence of onsequence of	f):	NCKR				
0 0	that initiated events resulting in death) Last	Due to	(or es e co	onsequenca of	j):					
he att	Pert II. Other significant conditions of	ontributing to death but not re	sulting in	the underlying	cause gi	ven in Part I.	23b. Dt	d tobacco use co	ntribute to	the cause of death
signed by the attendin d be detached for use d by Physiclan/N							10	Yes 2 No	3 Prol	bebly 4 Unknow
page 2 should i						- 154	24a. Wa	s an autopay tormed?	av.	ere autopsy findinga ailable prior to mpletion of cause death?
s certificate he director, page To Be Com							1	Yes 2 No	10	Yes 2□ No
octor Be	25. Wes case reterred to medical axaminer?	Unacital: a			100		eath (Check only	one)		
	1 Yes 2 No  27. Manner of Death  Falleture: 5 Pending	Hospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Year)	28b. T		DUA	her: 4 Nursing	*	sidenca 6 Oth how injury occur		N)
within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be determined		home, tar	m, street, tect		Yes 2 No		(Street and Numi	ber or Ruri	il Route Number,
within 24 hours effer deet To the Funeral Director: completely filled in by the Medical Certificat		ysician: To the best of my ki								
thin 24 or the F mplete	one)  29b. Signeture and title of certifier	and manner stated.				se number		29d. Date signe		
318	the state of certifier	MA					NGRELL			
Sol	A	completed cause of death (It		Type, Print)	1 1	DMCDICA	1 51/007	225	GRE	ENEST. AD 2:201
State	ARETHA NEISON  31. Date (flied (Month, Day, Year)  SEP 1 8 2000	32. Registrar's Sig	0F nature	MAKY	LAN	IN MEDICA	L 3 421	EM 50	LTO, A	10 21201

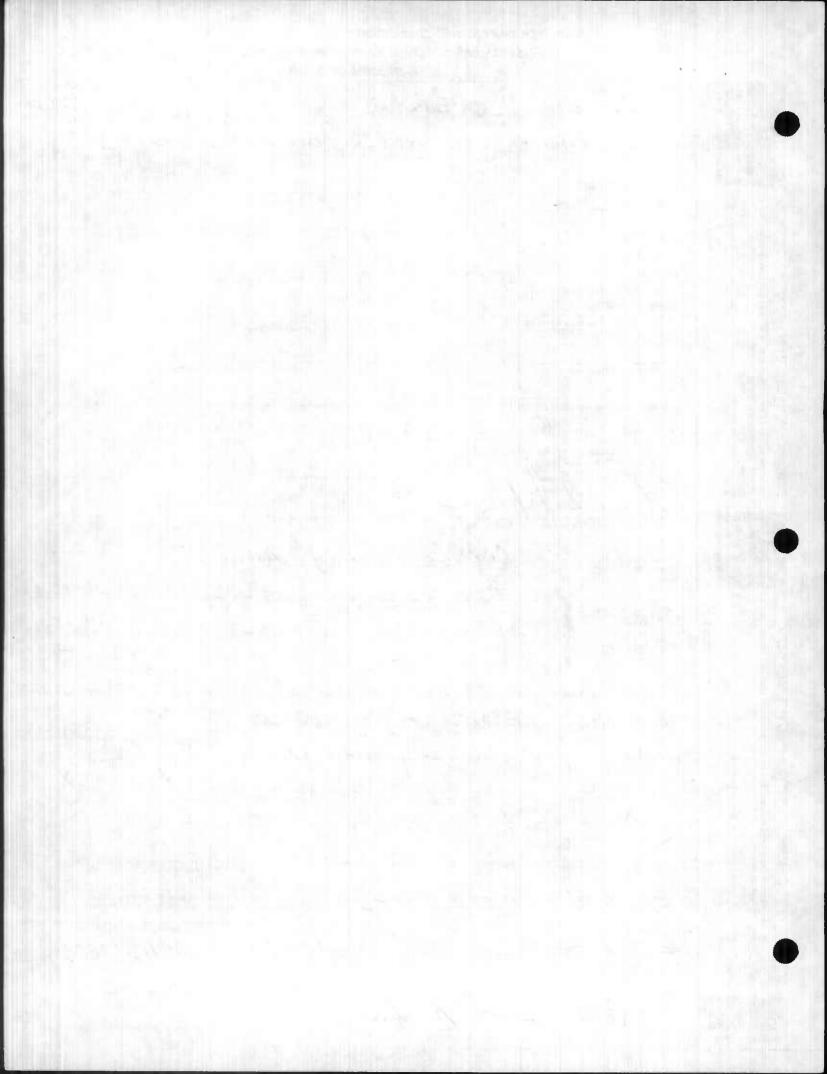
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State of Maryland / Department of Health and Mental Hygiene 29327

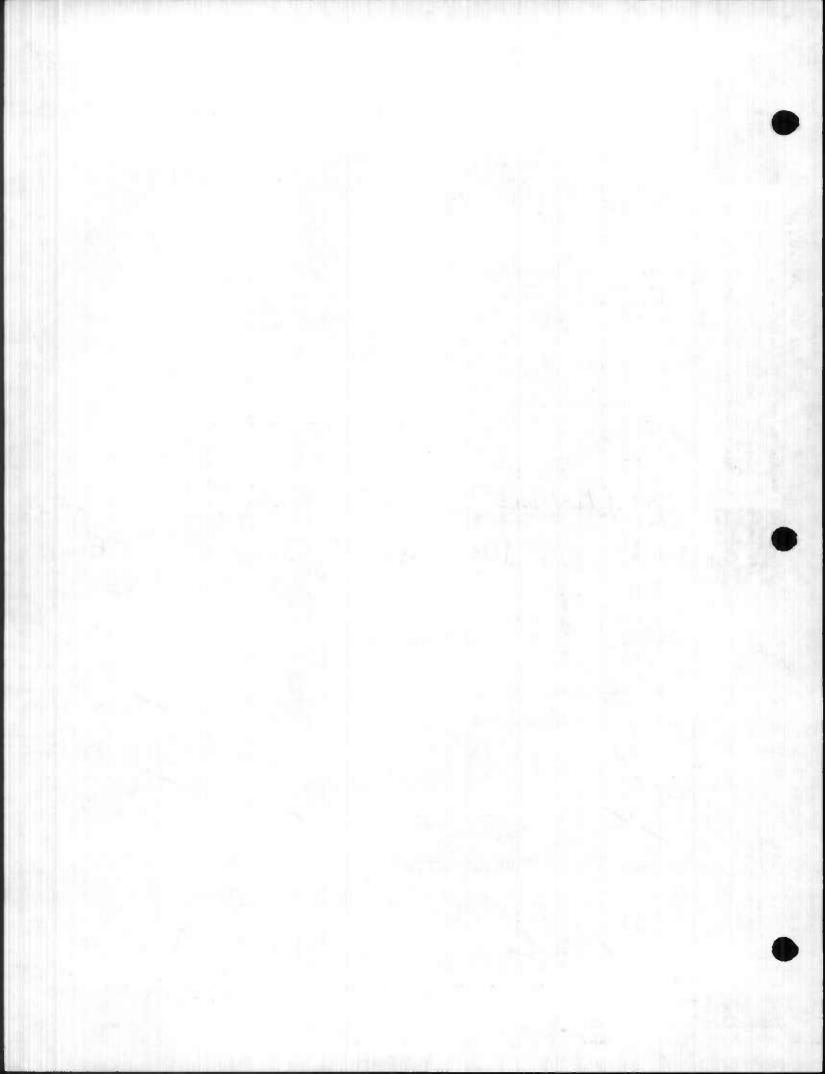
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T.	Physician /Medical	1. Decedent's Nema (First, Middle, I ELME	R COC	PER	SR.	-	2. Date of Dea Month	16 21	aar 500	Time of Death
	Examiner	4a Facility Name (If not institution, of Johns Hopkin	ive street and number)	Soul Ho	ATR	4b. City, Town, or	Location of Death	4c. County of	Death	
	Funeral Director		Sex 7. Ag	ge (In yrs. last birthda) 77 Yrs.	) If Under 1 Yea Months Days	r If Under 24 Hrs	8. Date of Birt	y, Year) y 15,1923	(COUNTRY)	(State or Foreign
		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	eastion					nside City Limits
with the Maryland	a dat		ore City	Baltimor						X Yas 2 No
the	be notified Director	10e. Streel and Number	ore orey	Darcimor	10f. Zip Coda			10g. Citizen of Wh	el Country?	
th with	23a or	5615 Mayview Av	enue		21206	5		United	States	S
5-0020 72 hours after death	at', or items	11. Marital Status  1 Never Married 2000Married  3 Widowed 4 Divorced	MAY- Oil		Was Decedent of If Yas, specify Cu 1 ☐ Yes 2 ☑ No	Hispanic Origin? (S ban, Mexicen, Puer Specify:	Specify Yes or No- to Rican, etc.)		American Inc White, etc. Bla	
5 2	acted design	15. Decedent's (Specify only highest of	Education trade completed)	16a. Dec	edent's Usual Occi	upation e during most of wo ed)	rking	16b. Kind of Busi	ness/Industry	1
2121 d within	ygiene.  Ser than "naturn  ft, the Medical  Completed	Elementery/Secondary (0-12)	College (1-4or	5+}		Attendant		Country	, Club	
	other of the Co	17. Father's Name (First, Middle, La.	st)	LOCK	EI KOOM F		me (First, Middle,	Maiden Sumeme)		
/lan	marked off	William R. Coop	er			Rosa Ani	n Prestor	n		
and sho	8 8 8	19a. Informent's Name/Retetionship	(Type, Print)	19b. Mai	ling Address (Street	et and Number or R	ural Route Numbe	er, City or Town, St	ate, Zip Code	9)
E -	hem 27 other tr	M. Marie Cooper	-Wife	561.		Avenue,	Baltimo	re, Mary] 20c. Location - C		
T 6	¥ # P	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec		cemetery, cri	ematory or other pi	eterans C	100			
Baltir Permit. P	Important: eny injury page.	21. Signature of Funeral Service 10	Leple		22. Name and Add Loudon Pa 3620 Wilk	rass of Facility ork Funera cens Avenu	al Home ie, Balt:	imore, Ma	ryland	1 21229
Phy	ysician	23a. Part1. Enter the disease, or co shock, or heart faiture. List on	mulications that cause typine cause on each li	d tha death. Do not en	ntar tha moda of dy	ring, such as cardia	c or respiratory as	rrest,	Inter	roximate rval Between set and Deeth
/N	Medical aminer	Immediate Cause (Final disease or condition	CA	EDIO PUL	MONAN	4 4	nnes	7		
		resulting in death)	1	Due to (or as a const	equenceyof):	)			1	3 Ilanos
O P	n and ial-transit	Canada Na Pintana di dan	b. 710	Due to (or as a cons	Hy de	a cepta	-105		100	HOURS
6	an and	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	02	THE BEL	1 ha	STRAL	CF.		24	1 Hours
68760 ficate be a	physiclan s the buria	Cause (Disease or injury that initiated events resulting in death) Last	с	Due to (or as a conse	quenca of):	217-01				
			d							
Box	the attending hed for use a	Don't Other designation distance	and the sales and a sales and the	A - A - Min - I - M		dura to Pond t	OOD DIA	lobacco una contr	dhuis to the	names of death?
P.O	ed by the attending detached for use y Physician/N	Part II. Other significant conditions METASTATIC	RECT	AL CA	- Hyne	ENTENSION	10	1	Probably	
Records,	tate has been signed by the attending page 2 should be detached for use a Completed by Physician/M	History of	P Myock	TRAINS.	Juffer	aren		an autopsy med?	availabl	utopsy findings le prior to ton of cause
	page 2	/ /					10	res 2 No	1 🗆 Yes	V
	s cartificate director, pag To Be Co	25. Was case referred to medical examiner?				26. Place of De	ath (Check only o	one)		/
of Vita	00	1 ☐ Yes 20 No	Hospitel: 1 Inpati		BUT 300A		7	dence 6 □Other		
E Bull	After fune	27. Manner of Death  1 Natural 5 Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time injury	W	uryat ork? ⊒Yes 2 □ No	28d. Describe	now injury occurred	1	
Division or Attending	al Director: After the in by the funeral Certification:	2 Accident invastigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of In	jury - At home, farm, s c. (Specify)			28f. Location (: City or Tox	Street and Number vn, State)	or Rural Rou	ute Number,
To the Hospital	within 2x nous and coeur.  To the Funeral Director: After this completely filled in by the funeral Medical Certification: 1	(Check only 2 Medicat Ex	Physician: To the best	f examination and/or i						
o the	o the omple	29b. Signature and title of certifier	and mannar st	ateO.	29c. Lice	nse number		29d. Date signed	(Month, Day,	Year)
F 3	8 = 8	1-	= no			1021		09/11	120	MA
	-U.9x	30. Name and address of person wh		leath (Item 23a) (Type	o, Print)	1001		01/16	100	
	CRs.	ADRIAN A	1, ORT	77 m)		WS HOPK	ms Ba	entless 1	uc.	
					7					



**ORIGINAL** 

**DHMH 16 Rev 6/95** 

MAY A A BOOK



by Be Completed

24b. Were autopsy tindings evailable prior to completion of cause ot death? 24e. Was an eutopsy performed? 1X Yes 2□ No 1 X Yes 2 □ No 25. Was cese referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence & Other (Specify) AT SCENE Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 11 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Death 1 X Netural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 ☐ Sulcida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, atreet, factory, office building, etc. (Specify) 4 Homicide 29s. Certifier

(Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number OCME

29d. Date aigned (Month, Day, Year) SEPTEMBER 10, 2000

1 Yes 2 No 3 Probably 4 Unknown

m who completed cause of deeth (Item 23a) (Type, Print)

JACK MI 111 Penn Street, Baltimore, Maryland 21201 31. Dete fited (Month, Day, Year) 32. Registrer's Signeture

State Registrar

Sporks

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this certificate has

al or Attending Physician: The safter death.

I Director: After this certificated in by the funeral director, pages of the funeral director, pages of the funeral director, pages of the funeral director, pages of the funeral director, pages of the funeral director, pages of the funeral director, pages of the funeral director, pages of the funeral director, pages of the funeral director, pages of the funeral director, pages of the funeral director, pages of the funeral director, pages of the funeral director, pages of the funeral director, pages of the funeral director of the f

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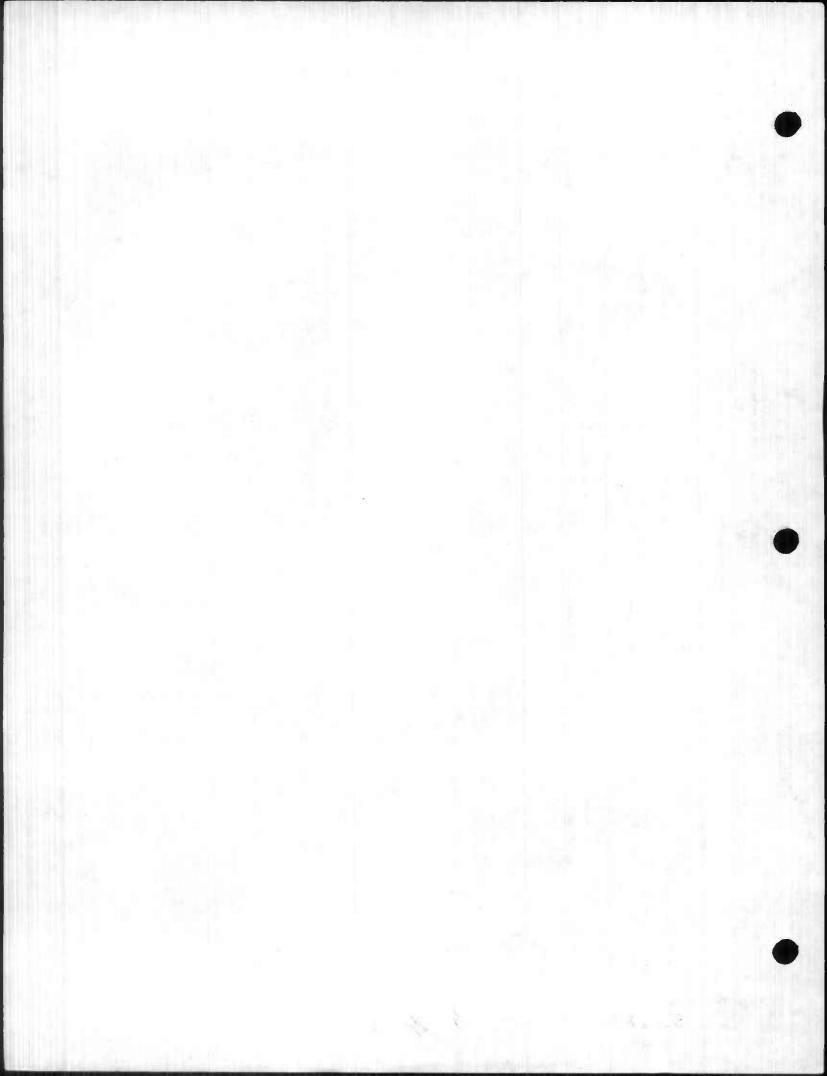
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Certification: To

Medical

of Vital Records,

Division

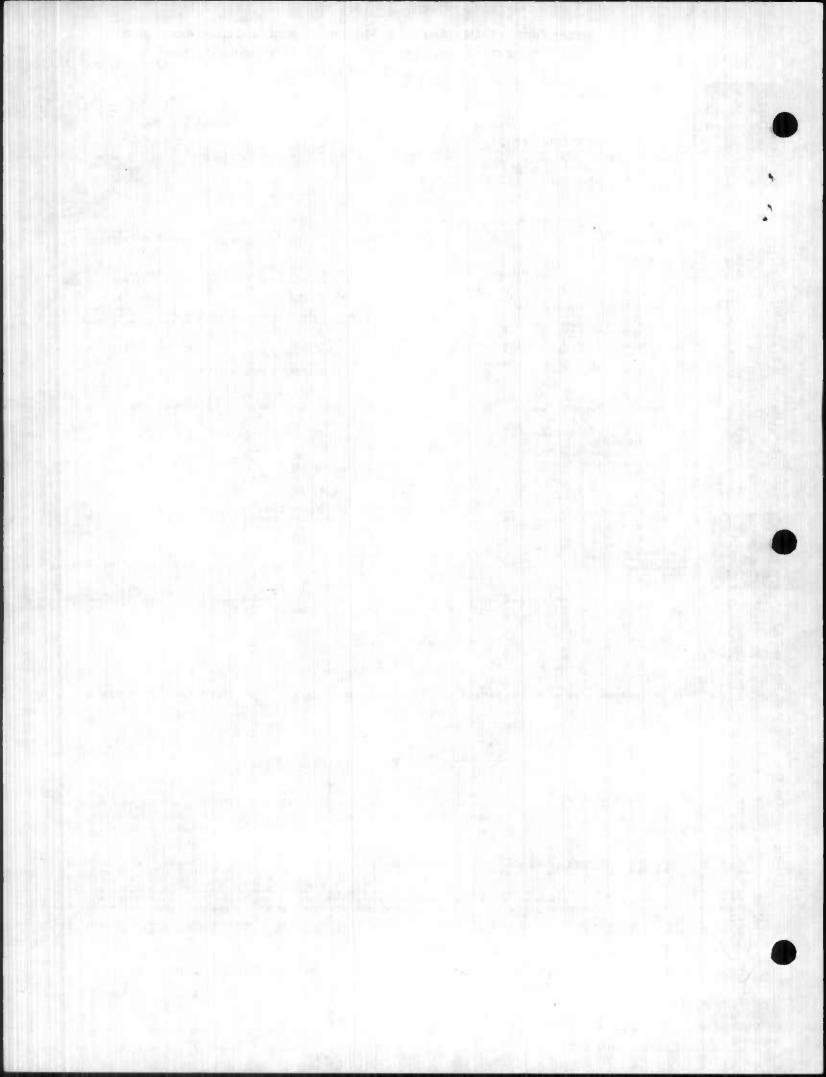


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State of Maryland / Department of Health and Mental Hygiene 0 29330

		Certificate of Death	Reg	. No.	3330
Physician	1. Decedent's Name (First, Middle, Last)  Nar (That Frazili		2. Date of Death Month Scallulu	Day 1th Year 12 2000	3. Time of Death
/Medical Examiner	4a Facility Name (If not institution, give street and number)  BOOD Samari Mrs Huspifal	4b. City, Town, or BRIHNIN	Location of Death	4c. County of Death	11 110111
Funeral Director	5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. let 215-28-6538 1 M 2 F 7.3	st birthday) If Under 1 Yeer If Under 24 Hrs Yrs. Months Deys Hours Min.	8. Date of Birth (Month, Dey, Y	(ear) 9. Birthe Cour	place (State or Foreign
P		Town or Location		1	10d. Inside City Limits
teta loc	Marylan Bathwork ZE	CISTERSHOUN			1 Nes 2 No
noffi rec	10e. Street and Number	10f. Zip Code	100	. Citizen of What Coul	ntry?
da da	39 BOND AVENUE	21136		USA	
ir, or heme 23e or 28e-i caminer must be notifie by Funeral Directo	11. Maritel Stetus  12. Wes Decedent Ever in U.S. Armed Forces?  1   Yes 2   No If Yes, Give Year or Dates:	. 13. Was Decedent of Hispenic Origin? (S If Yes, specify Cuban, Mexicen, Puer 1  Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Rece - Americ Bleck, White, Specify;	etc.
	15. Decedent's Education	16a. Decedent's Usual Occupation	16	b. Kind of Business/In	
ked other than "naturn ic event, the Medical. o Be Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give kind of work done during most of wo life. DO NOT use retired) Do M らんと	rking	rivate from	,4
Se vent	17. Father's Name (First, Middle, Last)		me (First, Middle, Me	1 1	
To	Louis Frazier, Se.	Angeli	ne Ringg	old	
er traums	LOUIS Fra ZIED, JR BROTHIN	01 201.2 1.		City or Town, State, Zip	
ny or oth		ce of Disposition (Name of metery, cremetory or other place) "Ant Rest Cometage	7 Mb/2000-	Location - City or To	ery/mm
any Inju 2005	21. Signature of Funeral Service Licensee	22. Name and Address of Facility C 5248 RUSTE RETURN BOHAMME, Al 212	LUMBS -	Namic En	rd Hims
ician dical	23a. Pert1. Enter the disease, or complications that caused the deeth. shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	Do not enter the mode of dying, such as cardia .	c or respiratory arrest	t. 1	Approximate Interval Between Onset and Deeth
niner	resulting In death)  Due to (or a	as a consequence of):			
as the buria-transit	if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury c	as a consequence of):			
lan	d				
d by Physician/	Part II. Other significant conditions contributing to death but not result	ing In the underlying ceuse given in Part i.		2 No 3 Pro	to the cause of death?
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s certificate director, par To Be Co	25. Was case referred to medical examiner?		ath (Check only one)		
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Funer pletely fill edical	29a. Certifier (Check only one)  1 Certifying Phyelclan: To the best of my knowl and menner stated.	on end/or investigation, in my opinion, death occ	urred at the time, date	e and place, and due t	to the cause(s)
N N	29b. Signature and title of certifier K. Tuge	29c. License number b 3066	1 32	1. Date signed (Month,	3 Th 2000
Sin	30. Name and address of person who completed cause of death (item:	23a) (Typa, Print) Sizeesh 7	RIPUR	ANENI	
5	3001 1000 ( 1-6	1 Hallugte - A	2-21	259	
State Registrar	31. Date filed (Month, Day, Year)  32. Registrar's Signatu	B. Souls			

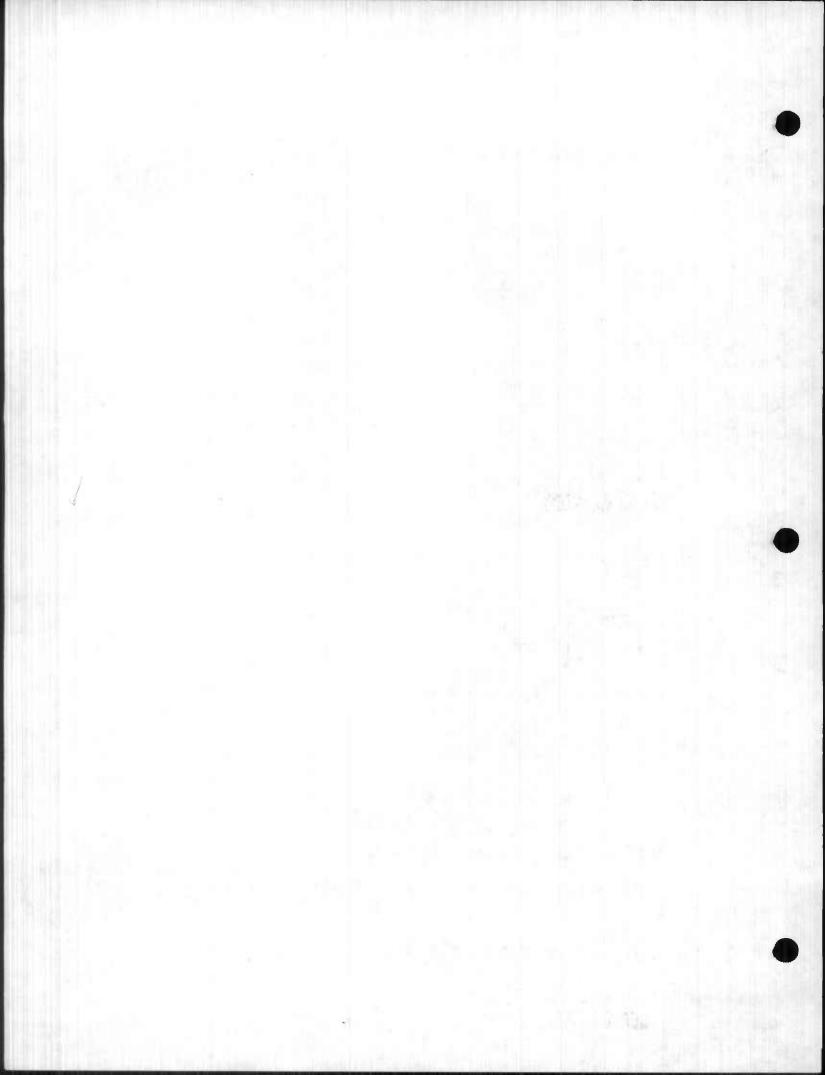
DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 00 2933 |

DARIN GRIF	FIN			Certifica	te of	Death		P	eg. No.			
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alvo al	10a. Stata 10b. County		10c. City, Town							1	Od. Insida City Limits	
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San de la company de la compan	1721 Chapel S	Street		2	121	3			USA			
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hou hou	29a. Certifier 1 Certifying	Physician: To the best o aminer: On the basis of	f my knowledge,	death occurred	at the tir	ne, date ar	nd place,	and due to tha	causa(s) and ri	iannar as s	stated.	
To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi		end mannar sta		o. mreangeno	., a. my C	parion, ue	000011	od at the third, t	and piece	, 2010 000 10	oaaaa(a)	
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1.1	30. Name and address of person wh	o completed aguas of di	ath them 220) T	ima Print								
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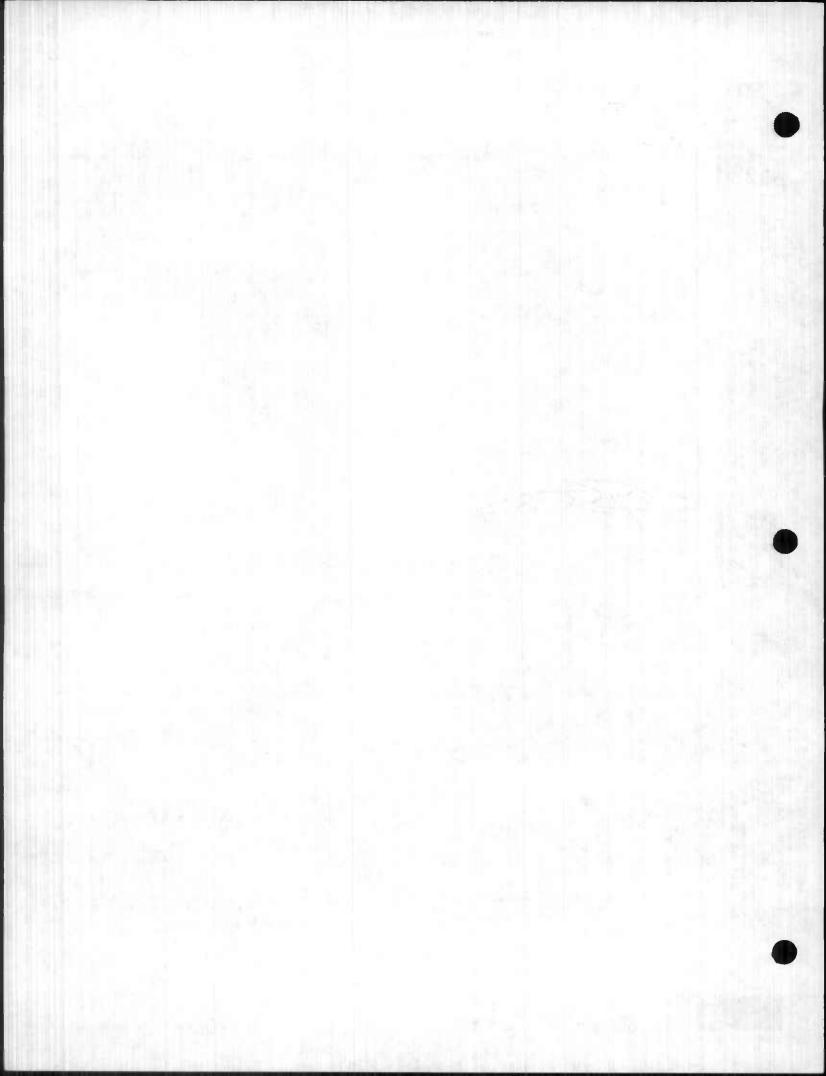
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) September 16, 2000 10:20 p.m. **Physician** Joseph Francis Gomeringer, Jr. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Baltimore 2411 Golupski Road 5. Social Security Number 6. Sex 2 F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplece (Steta Country) March 16, 1925 Maryland 7. Age (In yrs. last birthday) 9. Birthplece (Steta or Foreign **Funeral** Days Hours 216-20-2638 Yrs 75 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Wedical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2411 Golupski Road 21221 U.S.A. Funeral 14. Rece - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Merital Stetus filed within 72 hours after 1 ☐ Yes 2XXVo If Yes, Give Year or Dates: 1 Never Merried 20 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 12 Accountant Aero Space 17. Fether'a Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Tand 2 should be fill Health and Mental H em 27 is marked oft Joseph F. Gomeringer, Sr. Wilhelmina Pries 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2411 Golupski Road, Baltimore, Maryland 21221 nt of Health a Marie Gomeringer (wife) 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ☑Burial 2 ☐ Cremetion 3 ☐ Removal from State Department of Important: If any injury or page. Gardens of Fatih Cemetery 9/20/2000 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a Part1. Engine disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, showing a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last 68760. Due to (or as a consequenca of) Box ( P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown of Vital Records. Be Completed by 24b. Were autopsy findings svallable prior to completion of cause of death? 24e. Was en eutopsy performed? page 2 2 No 1 Yes 2 No 1 Yes 25. Wes case referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Netural 2 Accident 5 Pending Investigation 1 Yes 2 No 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the ceusa(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and dua to the ceuse(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of cartifie 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Bullmore, MD 21239 5801 Chang Lock 31. Date filed (Month, Dey, Year) 32. Registrar'a Signeture State

Registrar

SEP 1 8 2000



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THILITIN GIVON	LATRELL	GROSS
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LATRELL ASP	GR	OSS	State of Maryland	/ Department Certificate			giene () () Reg. No.	29333
Physic	rian	1. Decedent's Name (First, Middle, Last)		0 -		2. Date of De Month		3. Tima of Death
/Med	ical	LATROL  4a Facility Name (If not institution, giva s	MARTAZ treet and number)	GROS	4b. City, Town, or	SEPTEM Location of Deat		2000 1506
Exam	iner	900 BLK PENNSYLVAI			BALTIMO			NA
Funera Directo		5. Social Security Number 6. Sex 215-92-63/6	M 2 F 7. Age (In yrs. last	Yrs. If Under Months	Yaar If Undar 24 Hrs Days Hours Min.	8. Dafa of Bir (Month, Da	y Year)	9. Birthplace (State or Foreign Country) MARYLAND
nyland		10a. State 10b. County	10c. City, T	own or Location		1		10d. Insida City Limits
with the Maryland is or 28s-f show	ecto	MARYLAND BALTI	MORE	REI 10f. Zip	STERSTO	WN	10g. Citizen of W	1 No 2 No
h with	DIO	12367 BON	PRESTORI	VE	21130	0	И	SA.
720 rs after death with the Manyar r, or terms 23a or 28a-f ahow	by Funeral Director	11. Marital Sfafus 1  Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Evar in U.S. Armed Forces? 1 Yes 2 No H Yes, Give Year or Datas:	13. Was Decede ff Yas, speci	ent of Hispanic Origin? (S fy Cuban, Maxican, Puer No Specify:	pecify Yaa or No to Rican, atc.)	14. Race Black Specify:	- Amarican Indian, k, White, etc.
15-0020 72 hours at "natural", or		15. Decedent'a Educ (Specify only highast grada	aflon 1	6a. Decedent'a Uaual	Occupation	dina	16b. Kind of Bu	siness/Industry
d within Jiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use	e retired)	a	1241-	was die
CA ABP	Be Co	17. Fathar'a Name (First, Middle, Last)		LANO	18. Mother's Na	me (First, Middle	, Maiden Sumam	HORE CITY
# 0 # D 0	ToB	ALBERT		DHITE	BERI	VADIN	E	GROSS
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Ball permit. Depart mport my inj		21. Signature of Funaral Service License	11.21.	22. Name and	Address of Facility	ROWNi	TR. Fun	JERAL HOME
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ocuted nd transit	Examiner	Sequentially fist conditions,	Due to (or as	s a consequence of):				
8760, sete be axecuted hysician and the burial-transit	dical Ex	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events						
	Physician/Medic	resulting in death) Last	Due to (or as	a consequence of):				
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request should	Completed by					24a. Was	an autopsy ormed?	24b. Were autopsy findinga available prior to completion of cause ot death?
= F # d	Com					13	Yaa 2□No	1 ∰Yas 2 □ No
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= 5#5 E	Certification:	3 Sulcide 6 Could not be determined	28e. Plece of fnjury - At home building, etc. (Specify)			900 P	State) Pe	er or Rural Route Number,  Ansylvania av  poer as stated
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To the comp	Me	29b. Signature and title of certifier	94		License number			ER 10,2000
the	T	10	rler	111 I	Penn Street,	Baltim	ore, Mar	yland 21201
S: Regis	tate trar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	4 1	parka			

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/Medical	LOIS W.  4a Facility Name (If not institution, give sti		GROPP	4b. City, Town, or l		4c. County of Death	22010 11011
Examiner	University of Mary		Center	Baltim	ore	N/A	
Funeral Director	5. Social Security Number 6. Sex 1 1 1	7. Age (In yrs. 83			8. Dete of Birth (Month, Dey, NOV . 25		lace (State or Foreign try) H CAROLINA
and and	Usual Residence of Decedent  10a. Stete 10b. County	10c. Ci	ty, Town or Location			1	Od. Inside City Limits
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15 wit	120 5TH AVENUE			21061		U.S.A.	
office death v forms 234	11. Merital Stetus	. Was Decedent Ever in U Armed Forces?	.S. 13. Was Decedent of If Yes, specify C	f Hispenic Origin? (Suban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Americ Bleck, White,	
15-0020  n 72 hours after death with the Manyian "natural; or herma 23a or 28a-f show stical Examinat must be notified at leted by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 24 No If Yes, Give Year or Dates:	1 □ Yes 2 ☐ N			0	WHITE
5-6 72 h 72 h dise	15. Decedent's Educa (Specify only highest grade)	ition completed)	16a. Decedent's Usual Occ (Give kind of work dor life. DO NOT use ret	cupation ne during most of wor	king	16b. Kind of Business/Ind	dustry
	Elementery/Secondary (0-12)	College (1-4or 5+)	HOMEMAKER			OWN I	HOME
and be fill doth sven	17. Father's Neme (First, Middle, Last) ESPY E.	WARD		18. Mother's Nan CLARA	ne (First, Middle, Meiden Sumeme) HILL		
ryla hould d Men marke	ESPY E.  19a. Informent's Neme/Relationship (Type		19b. Mailing Address (Stre		rel Boute Number		Code
Ma nd 2 s and the and 27 is resu	MICHAEL H. GROPP	(SON)	120 5TH AVE				
s 1 ar (Heam Stem other	20a. Method of Disposition		Place of Disposition (Name of cometery, cremetory or other p	vace) O	/16/2000 <sup>2</sup>	20c. Location - City or To	own, State
Page Page mt: #	1 ☐XBurial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	EN HAVEN MEMOI			GLEN BURNIE	MD
Baitimore, Maryland 212 permit. Pages 1 and 2 should be filed with Department of the sells and Mental Hygiene. Important: if flem 27 is marked other than any injury or other traumatic avent, that once.  To Be Comp	21. Signature of Figure Service Licensee		22. Name and Add	dress of Facility SI	NGLETON I	FUNERAL HOM N BURNIE, MD	E, P.A.,
Physician /Medical Examiner	23e. Pert1. Enter the disease, of complex shock, or heart feilure. List only of the limited list of the list only of the list of the list only of the list of the	He	th. Do not enter the mode of control of the control	dying, such as cardiac	or respiratory arre	est,	Approximate triterval Between Onset and Death
death certificate be executed eath certificate be executed of eathending physician and bof for use as the burial-transit siclan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or Injury that initiated events resulting in deeth) Last	The last	or as e consequence of): or es e consequence of):				
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Vision of Attending Physical death.	27. Manner of Death 1 Netural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Del Year)		vork?	Sub;	ect Fel	2
Division case and a standard programmer of the transition of the t	3 Suicide 6 Could not be determined	28.1 Place of Injury - At h building, etc. (Speci	ome, farm, street, factory, offic fy)	08	28f. Location (St City or Town	eet and Number or Run, Stete)	A Route Number,
Hospi 24 hou Funer staty fill dical	29e. Certifier (Check only one)  1 Certifying Physic 2 Medical Examine	clan: To the best of my kno	owledge, death occurred et the etion end/or Investigation, in m	time, date and place y opinion, death occu	, and dua to the ce	euse(s) end menner as sate and placa, and due to	stated. the cause(s)
Me she	29b. Signeture and title of certifier		A 29c. Lice	ense number	25	9d. Date signed (Month,	Dev. Year)

State Registrar

30. Name and accress of person who completed cause of death (Item 23a) (Type, Print)

PS fawer 111 Penn Street, Baltimore, Maryland 21201

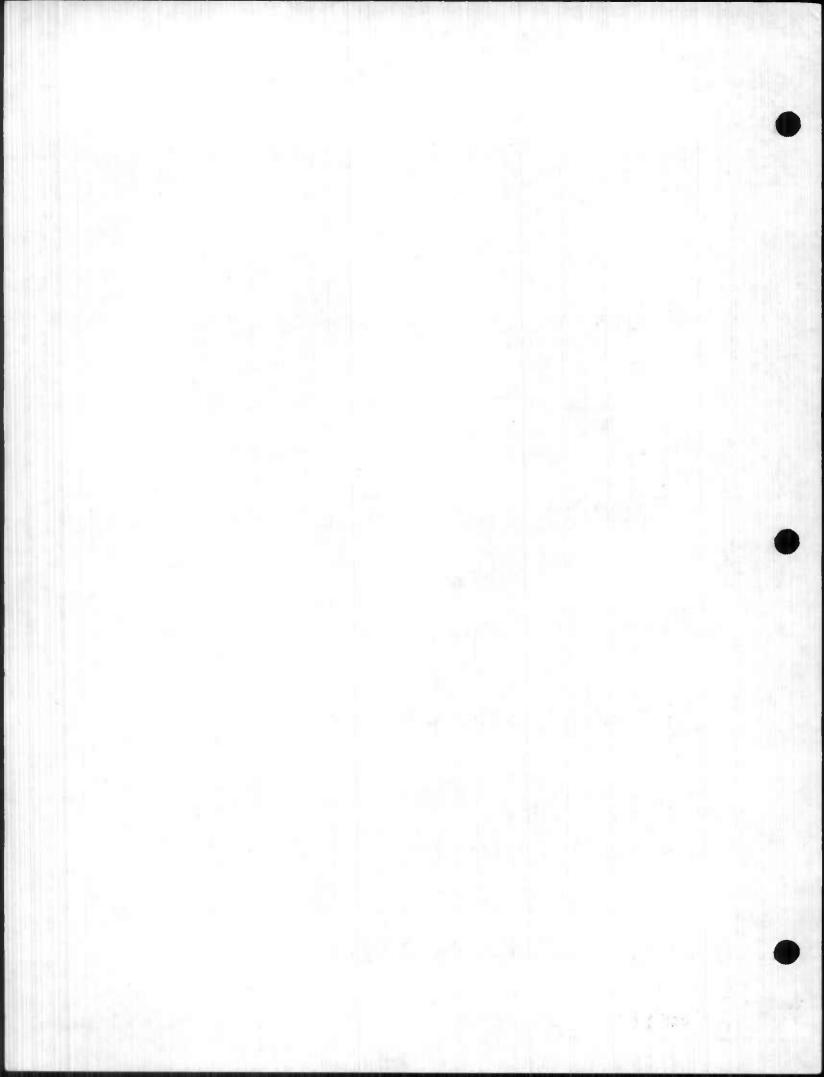
31. Date filed (Month, Dey, Year)

32. Registrar's Signature

DHMH 16 Rsv 6/95

O.C.M.E.

September 13, 2000



Please Type or Print in Black indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Deeth 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** LOUIS MHOL GETTIFR /Medical 4b. City, Town, or Location of Deeth 4a Fscility Name (If not institution, give street and number) 4c. County of Death Examiner 10312 LONGWOODS KOOC ASTON If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) **Funeral** Months Days Hours 1 M 2 F 018-10-5048 Yrs Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ? Is marked other than "natural", or flams 23s or 28s-f show traumstic avant, the Modical Examiner must be notified at 1 ☐ Yes 2 ☐ No TALBOT Director EASTON 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 2160 ONGWOOS UNITED 103121 Funeral 12. Was Decedent Ever In U.S. Armed Forcas?

1 Dayes 2 Do No If Yes, Give Year or Dates: 14. Race - American Indien, Black, White, etc. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11 Marital Stetus 1 Never Married 2 Married Baltimore. Maryland 21215-0020 1□ Yes 2 No Specify: WHITE 2 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) BOARD OF EDUCATION JANITOR 0 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) permit. Pages 1 and 2 should be filt Depertment of Heelth and Mental Hy Important: if Item 27 is marked oth any lojury or other traumatic avant ROSS. Thomas E. GETTIER AURA 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) DILLIAM GETTIER 10312 SON EASTON, MD 2160 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State GIFTFOUNDATION 9-5-00 LAUREL, MD 4) Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility ANATOMIC GIFT FOUNDATION 21. Signeture of Funeral Service Licensee GALTIMORE AVE laurel. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or es e consequença of) as the ed by the attending detached for use as Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ should be 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy Ventricular Tachycardia 1 ☐ Yas 2 ☐ No 1 Yes 2 3 NO l or Attending Physician: after death. after death.

Director: After this certific d in by the funeral director. 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Lo 1 Yes 2 No 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Naturat 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 I Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and menner stated. Medical 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 29c. License number DO05360Z Helma

Registrar DHMH 16 Rav 6/95

606 Dutchman

Easton MD 21601

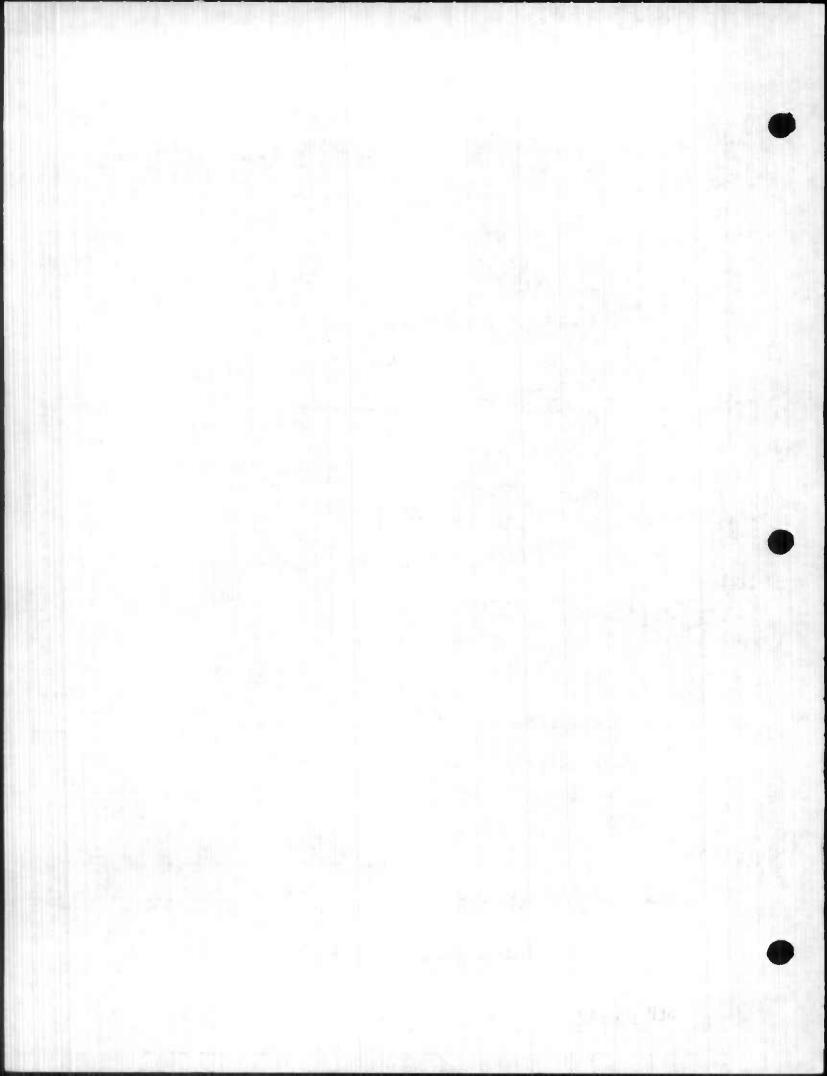
30. Neme and address of person who completed cause of death (Item 23e) (Type, Print)

32. Registrar's Signature

Carolyn Helmly, MD

31. Rate filed (Month, Day, Year)

SEP 1. 8 2000 Security

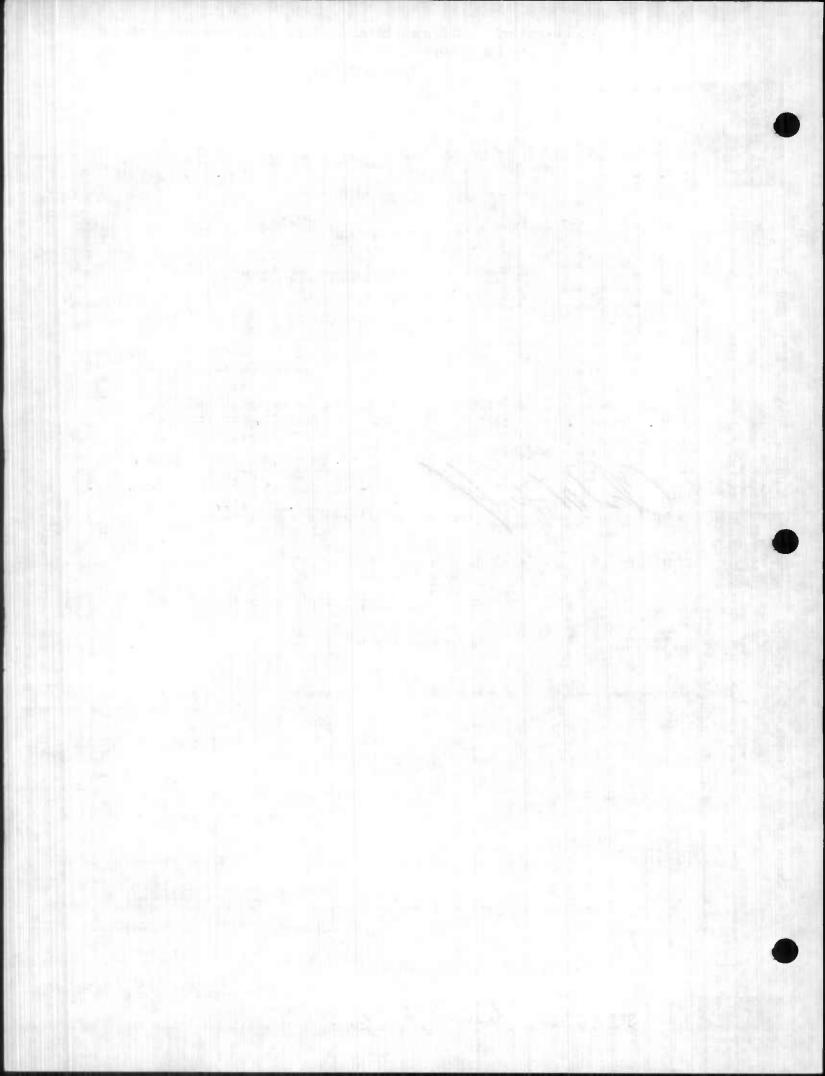


# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 29336

			C	ertificate of D	eath	Reg. No.	23330
		1. Decedent's Nama (First, Middle, Last)			2. Data o	Death	3. Time of Death
	Physician /Medical	Dean	d number)	orands	tutt sepi	em ber 14, .	
	Examiner	4a Facility Nama (If not Institution, giva street and	d number)	4b	. City, Town, or Location of D	eath 4c. County of	Death
		Johns Hopkins 13	ay view Med	12a/Conter	Baltimore,	.mo	N/A
	Funeral Director	5. Social Security Number 6. Sex 1 M 2 Usual Residence of Decedent	7. Age (In yrs. last birthda F 51 Yrs.	Months Days	Hours Min. 8. Date of (Month) Dec.	Birth Day, Year) 31,1948	9. Birthplace (State or Foreign Country) Indiana
	F 8-11	10a. State 10b. County	10c. City, Town or	Location			10d. fnside City Limits
	Mary Lab Beda	Maryland Baltimore		D	unda1k		1 ☐ Yes 2 No
	or 28a-f a	10e. Street and Number		101. Zip Code		10g. Citizen of Wh	et Country?
		2025 Guy Way			21222	United	States
21215-0020	un after death v af, or flame 23s Examiner must by Furnaral	Arme 1 □ Never Married 2 ☑ Married 1 □ V	Decedent Ever in U,S. 1 d Forcas? les 2 3No s, Give or Datas:	Was Decedant of His if Yes, specify Cuban     □ Yes 2 X No	panic Origin? (Specify Yes o , Mexican, Puerto Rican, etc. Specify:	r No- ) 14. Race- Black, Specify:	American Indian, White, etc. White
0-5	2 ho	15. Decedent's Education		cedent's Usuai Occupat iva kind of work dona du	ion	16b. Kind of Busi	ness/Industry
21	ed within 72 ho ygiene. her than "neturn ft, the Medical.	(Specify only highest grade comple Elementery/Secondary (0-12) Colle	ge (1-4or 5+)	e. DO NOT use retired)			
2	A the state of	11 Years	Wa	rehouse tec			cturing
Pu	H days	17. Fathar's Name (First, Middle, Last)			18. Mother's Neme (First, Mi		
yla	Men Men To	Edwin Grandstaff	w.fo		Ruth Perry		
, Maryland	and 2 sh with and 27 is m ac traum	19a. Informant's Name/Relationship (Type, Print) Mrs. Elaine M. Grands			Dundalk, Mary		
altimore	Pages 1 vent of Hs not: If then rry or oth	20a. Method of Disposition  1  Burial 2 □ Cremation 3 □ Removal f  4 □ Donation 5 □ Qther (Specify)	cemetery, c	sposition (Name of crematory or other place) idge Mem. E	Park 9/17/2000		ity or Town, State Maryland
Balti	Departr Departr Imports any Inja	21. Signature of Fatter Service Licensee	6/		Funeral Home		
		23a. Part1. Enter the disease, or complications to	nat orusad tha daath. Do not	7922 Wise	Ave. Dundalk,	Maryland or arrest.	21222 Approximate
	Physician	23a. Part 1. Enter the disease, or complications to shock, or heart failure. List only one cause	og each line.				friterval Between Onset and Death
	Physician / /Medical	immediate Cause (Final	tio Charli	0-17 1.	Carin	000	
	Examiner	disease or condition resulting in death)	In Small  Due to (or as a con  Anstatic lung	27/1 40	ing chille	16,000	
	و السنا	Me	tastatic line	a lance	to bear 1	una elec	
	od ransit	Sequentially list conditions	Due to (or as a con	sequence of):	10 1001, 1	day, Spice.	
ó	ficate be executed g physician and as the burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
68760,	ysici he bu	that initiated events resulting in deeth) Lest	Due to (or as a con-	sequence of):			
	2 0 a	and the second second second second					
Box	death center of for usa	d					
0.	at the death cert by the attendin etached for usa	Part fl. Other significant conditions contributing	to death but not resulting in th	e underlying cause give	n in Pert f. 23b.	Dfd tobacco use cont	ributs to the causs of death?
P.0.	that the detache				1090 LT	1 7 Yes 2 No	3 Probably 4 Unknown
Vital Records,	2 53 0			- yale itali		Was an autopsy performed?	24b. Were sutopsy findings available prior to
3ecc	2 % N C						complation of cause of death?
a	icate ha					1 ☐ Yes 2 ☐ No	1 Yes 2 No
N N	Physician: this certific ral director,	25. Was case referred to medical examiner? Hospitel:	d	Other	26. Place of Death (Check of		10 7/1
	Physic this constant direction	TLI Fas 2 NO	1 Inpatient 2 ER/Outpa	tient 3L DOA	4   Nursing Home 5	ribe how injury occurre	
on	After fune	la contra di contra di	Date of Injury Month, Day Year) 28b. Time finjury	ry Work'	? es 2□No		
Division of	To the Reephal or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be	3 Suicide 6 Could not be	Place of fnjury - At home, farm, building, etc. (Specify)	street, fectory, office		on (Street and Number r Town, State)	r or Rural Routa Number,
	To the Hospital of within 24 hours at To the Funeral Discompletely filled in Medical Cell.		the best of my knowledge, de				
	in 24 hou in 24 hou he Funer pletely fil		ne basis of exemination and/or manner stated.				
	Within To the Common	29b. Signatura and titla of certifier	1 0	29c. License			(Month, Day, Year)
	()	Jul /4 /	ans X	2030	S/RES ØDO	0 9/14/0	V
	Mail	30. Name and address of person who completed	cause of death (Item 23a) (Ty	pe, Print)	S/RESØØ	11	
	40'	Sheila Conzulgo mo		1440 tal	tern Are &	alto, mo	31224
	State Registrar	SFP 1.8 2000	2. Registrar's Signature	Thou V			

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPT. **Physician** MARIE MAGLINE HARRIS 2000 50 AM 16 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE OSEPH RICHEY TOSPIC 8. Dete of Birth (Month, Dey, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex Birthplaca (Steta or Foreign Country) **Funeral** 1 M 25 F Months Days Hours 212-24-8826 Usual Residence of Decedent Director 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 1 ¥ Yas 2 No Directo MARYLAND 10e. Street and Number 10f. Zip Code 10g. Clizen of What Country? traumatic event, the Madical Examiner must be 8 AVENUE USA Funerai 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Merital Stetus Black, White, etc. 1 ☐ Never Married 2 ☐ Married 6 1 Yes 25 No Specify: Specify: BLACK þ 3 N Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Marie Harris Elementary/Secondary (0-12) College (1-4or 5+) HIGRADE WORKER PRIVATE HOMES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be un and Mental I 10 HENRU MATTHEWS LOR 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) + ORTENSE M. THOMAS DAUGHTED 2 8 17 BOAR MAN)

20e. Method of Disposition

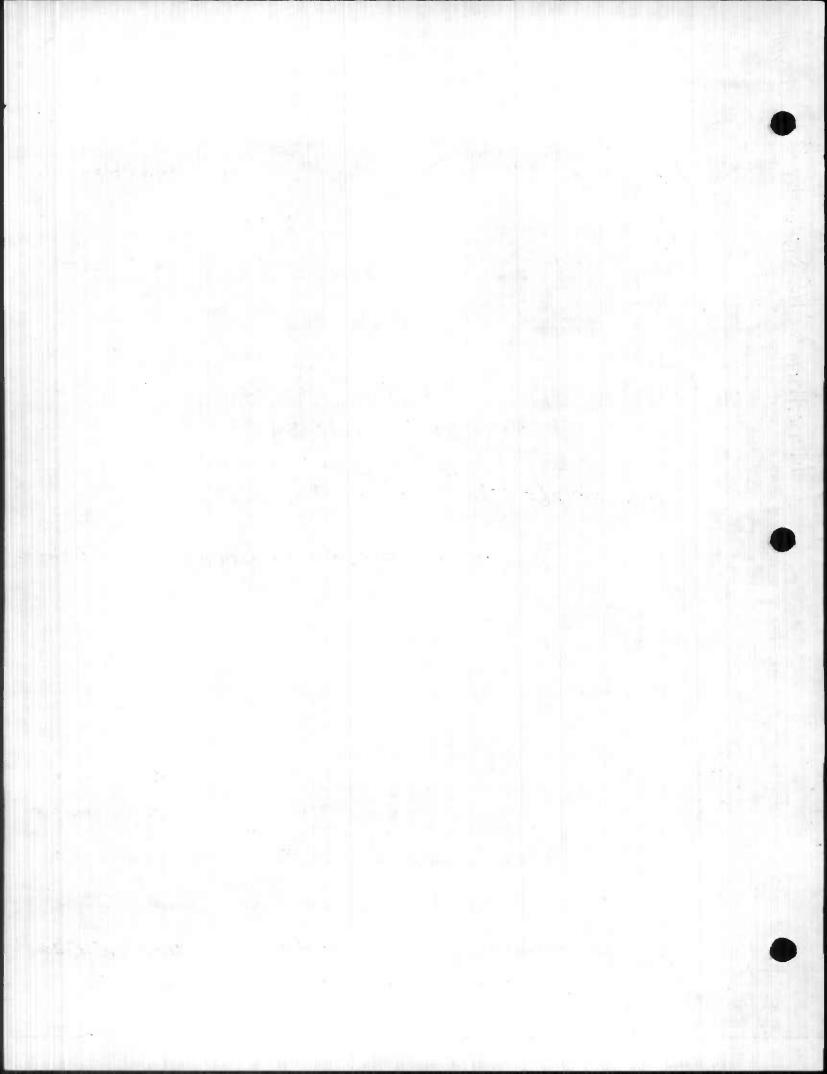
20b. Piece of Disposition (Name of camelory, cremetory or other piece) Department of Health Important: If Item 27 I AVE. BALTIMORE, MD. 2/2 15
20c. Location - City or Town, Steta Date / any injury or c 1 Burial 2 ☐ Cremetion 3 ☐ Removet from Stete 9-20-00 4 □ Donetion 5 □ Other (Specify) PARK WOODLAWN, MARYLAND KING MEMORIAL 22. Name and Address of Facility

22. Name and Address of Facility

BROWN

1950 N. FULTON AVE. 21. Signeture of Funeral Service Lipen BROWN JR. FUNERAL Home BALTIMORE, MO-2121 Approximete tnterval Between Onset and Deeth 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart feiture. List only one cause on each line. **Physician** /Medical Immediate Cause (Finat disease or condition resulting in death) LUNG CANCER MONTAS WITH METASTASES Examiner Due to (or as e consequence of): Examiner attending physician and lor use as the burial-tran Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): certificate be exec Box 68760. Physician/Medical Dua to (or as a consequence of): P.0. Part II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Division of Vital Records, 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy parformed? Completed certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 KNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) HOSPI C 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Inneral 27. Menner of Death 28a. Deta of Injury (Month, Day Year) 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury at Work? 1 Maturel 5 Pending investigation death. 1 ☐ Yas 2 ☐ No 2 Accident after death Director: 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 24 hours Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier edical completely (Check only one) To the F within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier D09633 Muchble mo SATTEMBER 18 2000 30. Name and address of parson who completed cause of deeth (flem 23a) (Type, Print) JOHN B MAC GIBBON 300 ARMORY PLACE SUIVE 39. BALTIMORE MD 21201 31. Date filed stores, Dey, Year, SEP 1 8 2000 32. Registrar's Signeture State Registrar DHMH 16 Rev 6/95



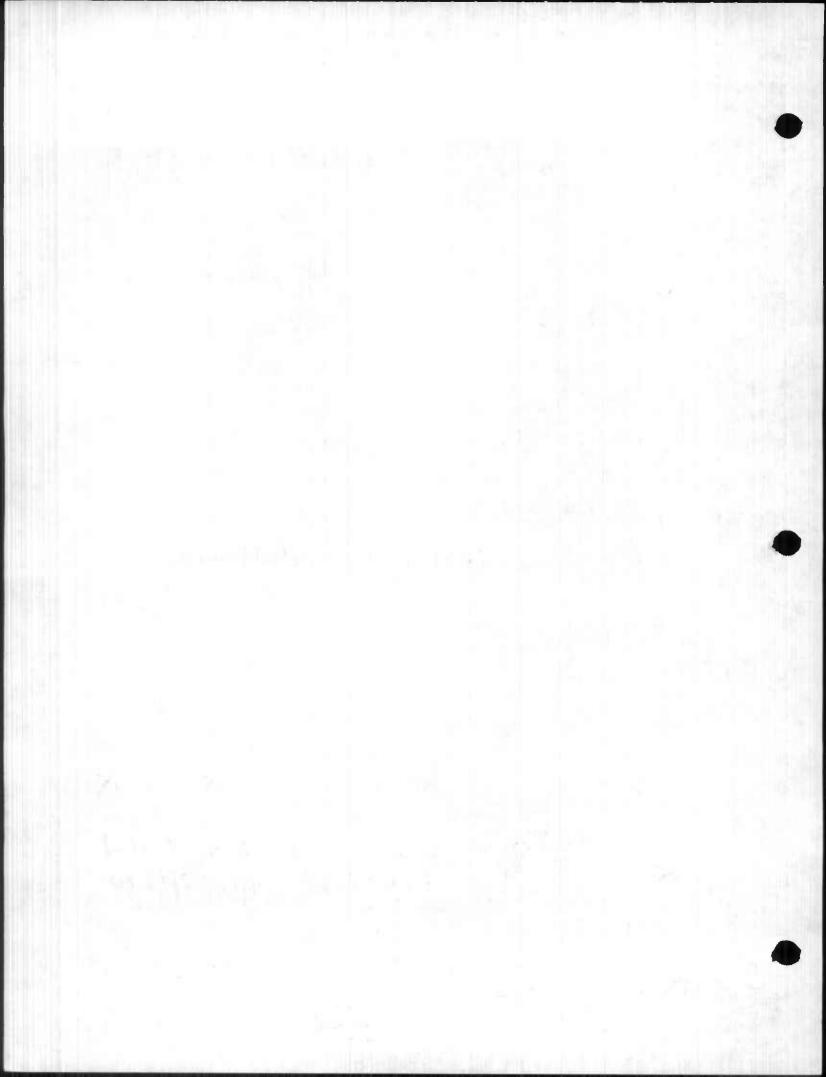
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

ysician	LYES				Dealli		Reg. No.		
	1. Decedent's Name (First, Middle, L	ast)				2. Date of D Month			Time of Death
Medical :	RANDOLPH C	CORNELIUS	HOLMES	.IR	1166	SEPTE	MBER 16,	2000 0	3:05 AM
aminer	4a Facility Name (If not institution, gi					m, or Location of Dea	th 4c. County	of Death	
	4500 CLIFTON RO	AD			BALTIN			/A	
eral	Social Security Number 6.	ADD A SOUTH	e (In yrs. last birthda	y) If Under 1 Year Months Days		4 Hrs. 8. Date of B	irth (Pay, Year) 2,1970	9. Birthplace Country)	(Stete or Foreign
ctor	220 /2 8//9	M ZLIF	29 Yrs.			OCT.	2,1970	MARYLA	ND
	Usual Residence of Decedent		40a Chi Taura	Lanation				Tank 6	old Ob Links
Exemples must be notified at by Funeral Offector	10a. State 10b. County		10c. City, Town or						Side City Limits Yes 2 No
ct o	MD. N/A		BALTI	MOKE				77	L 162 2 NO
olre	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?	
ai ai	3110 MARECO	AVENUE		21	1213		U.S. 0	F A.	
Funeral Director	11. Marital Status	12. Was Decedent	Ever in U,S. 13	B. Was Decedent of	Hispanic Orig	in? (Specify Yes or N Puerto Rican, etc.)	lo- 14. Rac	ce - American In	dian,
3	1 Never Married 2 Married	Armed Forces? 1  Yes 2001 If Yes, Give	ło	1 ☐ Yes 2 No		T don'to t mount, oto.,			
by	3 Widowed 4 Divorced	Year or Dates:		10 105 20110	Specify.		Specif	BLACK	
Completed	15. Decedent's E (Specify only highest gi	ducation	16a. Dec	cedent's Usual Occu	pation	of working	16b. Kind of B	usiness/Industry	/
ple	Elementary/Secondary (0-12)	College (1-4or !	i+)	ve kind of work done DO NOT use retire	ed)	or working			
PO	UNKNOWN	UNKNOWN		EMPLOYE	)		r	10 ne	
Be	17. Father's Name (First, Middle, Las	(1)			18. Mother	's Name (First, Midd	le, Maiden Surnat	me)	
10	RANDOLPH CORN	ELIUS H	DLMES, S	R.	SHAF	RON DAVI	S		
	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	iling Address (Stree	and Number	r or Rural Route Num	ber, City or Town	, Stete, Zip Cod	Θ)
100	NOMORYA LEE HO	LMES (W	IFE) 311	0 mareco	aver	nue BALT	IMORE.M	D. 212	13
	20a. Method of Disposition		20b. Place of Dis	position (Neme of rematory or other pla		Dete		· City or Town,	
	1 Burial 2 ☐ Cremation 3 6 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	ARBUTU	S MEMOR	TAL PA	ARK 9/21	OO BAL	TIMORE	
	21. Signature of Fupreral Service Lice			22. Name and Addr					,
DUC	7	TENIS I	GWINN	LEWIS T.		IN FUNER	AL HOME	2121	5-6393
	rewis -	Lugni	4	517 PARI	HEIC	GHTS AVE	NUE BA	LTO. M	ID.
10	23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications wat caused y one cause on each li	the death. Do not e	inter the mode of dy	ing, such as c	cardiac or respiretory	arrest,	Inte	roximate rval Between
cian			10	.1 (		1 1.	-	Ons	et and Death
ical er	Immediate Cause (Final disease or condition		Noth	De V	unel	Lether	nds		
	resulting in death)		Due to (or es e cons						
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edical Examiner	Sequentially list conditions,	0	Due to (or as a cons	equence of):					
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00	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause g	iven in Part I.	23b. DI	d lobacco use co	ontribute to the	cause of death?
hysic	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause g	iven in Part I.		d tobacco use co	ontribute to the	
y Physician	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause g	iven in Part I.		An		
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by	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause g	iven in Part I.	1[ 24a. We	Y 90 2/00	3 Probably  24b. Were a availab comple	utopsy findings le prior to tion of cause
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edical Certification: To Be Completed by	25. Was case referred to medical axaminer?  1 M Yes 2 No  27. Menner of Death 1 Netural 5 Pending investigating the formicide of the mine.	Hospital: 1 Inpatia  28a. Deja of Injunt  on be 28e Face of Injunt  uilding, et	ont 2 ER/Outpat  Year) 28b. Time Injury A home, ferm, . (Specify) of my knowledge, de examination and/or	ient 3 DOA O	26. Place ther: 4 Nur uny at ork? Yes 2	of Death (Check only rsing Home 5   Re 28d. Describ City or 7	Yes 2 No  Yes 2 No  No None)  Sidence 6 Note how injury occur  (Street and Numown, State)  e cause(s) and m	24b. Were a availab comple of death  Area for their (Specify) arred their or Rural Roll Roll Roll Roll Roll Roll Roll Ro	utopsy findings le prior to tion of cause n?  s 2 No  SCENE
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pletely filled in by the funeral director, page 2 should be dedical Certification: To Be Completed by	25. Wes case referred to medical axaminer?  1 New 2 No  27. Menner of Death 1 Netural 5 Pending investigating inve	Hospital: 1 Inpatie 28a. Deje of Inju tohnin de d 28a. Lace of Inju tohnin de investigation: To the best	ont 2 EP/Outpat  Ty 28b. Time Injury  A home, ferm,  (Specify)  of my knowledge, de examination and/or ted.	ient 3 DOA Or 28c. Injury William III.  street, factory, office of investigation, in my 29c. Licer	26. Place ther:  yest ork?  Yes 2  wime, dete end opinion, deatt ase number	of Death (Check only rsing Home 5   Re 28d. Describ City or 7	Yes 2 No  No No No No No No No No No No No No No N	24b. Were a availab comple of death  Area to the result of	utopsy findings le prior to tion of cause ??  s 2 No  SCENE  ute Number,  cause(s)



## State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month Day **Physician** September 13,2000 HOFFMAN SIDNEY R. /Medical 4a Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Hospital of Sinai If Undar 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yaar) MAR.30,1924 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 MM 2□ F 216-20-3976 Yrs. 76 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location apour s Director 28a-f BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò must be 5 COBBLER COURT 21208 therrie 23a U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marifal Status Black, White, etc. 1 Navar Married 2 Married 1 X Yas 2 No If Yes, Give b WWII 1 ☐ Yas 2 ☒ No Specify: SIDNET Specify: À 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PROPRIETOR AUTOMOTIVE 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17 Father's Name (First Middle Last) Be and Mental F ahould be OFFMAN, SAMUEL **HOFFMAN ESTHER** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health ar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

5 COBBLER COURT - BALTIMORE, MD 21208

20b. Place of Disposition (Name of cemetery, crematory or other place)

MARCO ISLAND CEMETERY

22. Name and Address of Facility

28c. Injury at Work?

1 ☐ Yas 2 ☐ No

TAH

Physician /Medical Examiner

of Health Nem 27 I

ò Department Important: If any injury or

Baltimore,

The lew requires that the death certificate be executed use es the burial-tran Box 68760, P.O. of Vital Records, 2 eged certificate hes Physician: funeral director, After this

after death.

within 24 hours a To the Funeral C Hospital

To the

in by

completely

State

Division or Attending Medical Certification: To Be

23a. Part1. Enter the disease, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disaasa or condition resulting in death) Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that Initiated events rasulting In daafh) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. adeno carcinoma by Completed

ISABEL B PRICE HOFFMAN / WIFE

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify)

20a. Method of Disposition

21. Signature of Funaral Service Licensee

23h. Did tohacco use contribute to the cause of death? No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performad? 1 Yas 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred 281. Location (Street and Number or Rural Route Number, City or Town, State) ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)

29339

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

N/A

WHITE

(UNKNOWN)

Approximate Interval Between Onset and Daath

20c. Location - City or Town, State

9/15/00 MARCO ISLAND, FL

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

SOL LEVINSON & BROS., INC.

3. Time of Death

4:06 Pr

29a. Certifier (Check only one)	2 Medical Examiner: On the			occurred at the time, date and placestigation, in my opinion, death occ
29b. Signature an	d'title of certifier	TAN	MD	29c. License number RES 000

28a. Date of Injury (Month, Day Year)

Inpatiant 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29d. Date signed (Month, Day, Year)

September 13,2000

HENRY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Ballimure, 2401 West Beliedere Ave, Ballimure, MD

Hospital:

5 Pending invastigation

6 Could not be

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

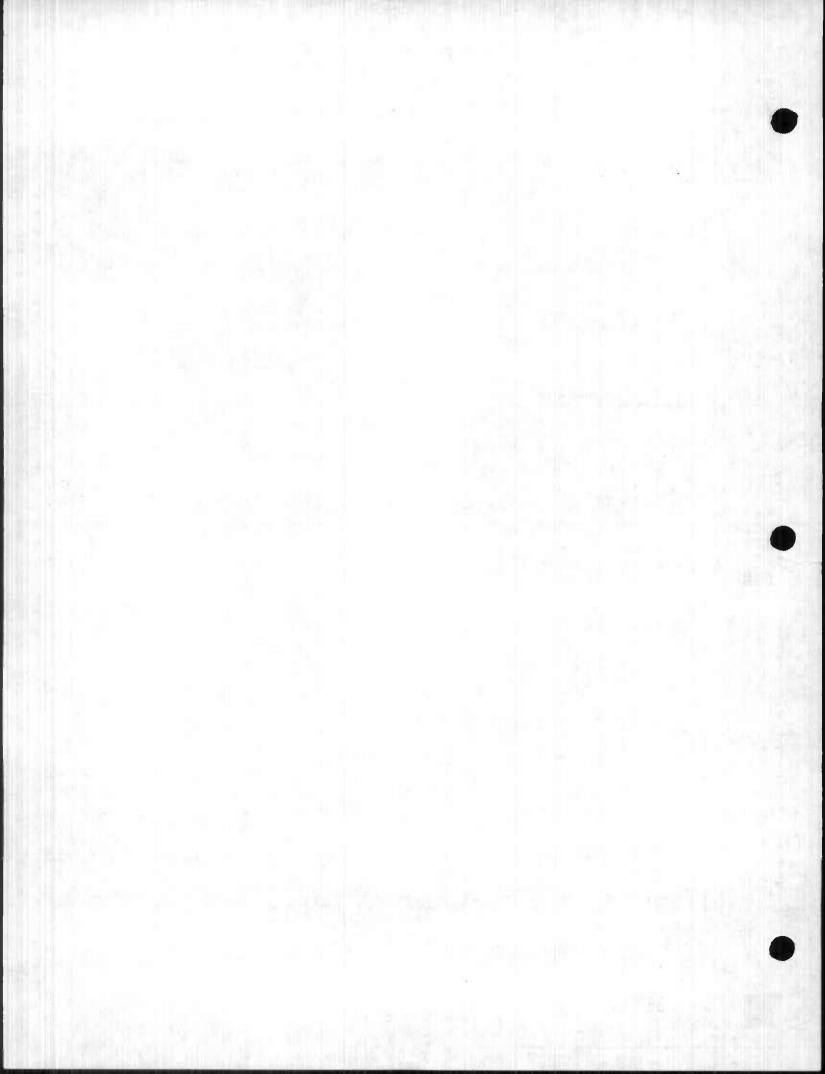
1 Natural 2 Accident

3 Suicide

4 Homicide

32. Registrar's Signatura

Darks



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death George Joseph Henderson, Jr. 5:30 PM September 13,2000 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Death 868 Jaydee Avenue Dundalk Baltimore If Under 1 Yeer If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Days ₩ 2□ F 72 Vrs 220-20-8933 Maryland Oct. 3,1927 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limite 1 ☐ Yes XX No Dundalk Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 868 Jaydee Avenue United States Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☐ No
If Yas, Give
Year or Dates: 1945-48 1 Nevar Married 2 Married 1 ☐ Yes 2 ☐No Specify: Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Newspaper Elementery/Secondary (0-12) College (1-4or 5+) Stereotyper Printing 11 Years 17. Fether's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Eleanor Albrecht George J. Henderson, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 868 Jaydee Ave. Dundalk, Maryland 21222 Mrs. Erma C. Henderson (Wife) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Gardens of Faith Cem. 9/16/2000 Baltimore, Maryland 4 Donetion 5 Other (Specify) Entombmen 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that ceuser if e death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each Immediata Causa (Final MO disease or condition rasulting in daath) METASTATIC SQUAMOUS CELL CARCINOMA OF THE LUNG Due to (or as a consequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as e consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? TWYes 2 No 3 Probably 4 Unknown MELLITUS DIABETES 24e. Was en eutopsy performed? 24b. Were autopsy findings available prior to PERIPHERAL VASCULAR DISEASE completion of cause of daath? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes casa raferred to medical examinar? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ■ Rasidence 8 Othar (Specify) 1 Yes 2 No 28b. Time of Injury 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 MNatural 1 Yes 2 No 2 Accident

lcian and burial-trans Box 68760. the USe P.O. Records, of Vital this Division Attending

Be Certification: To filled in by

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

show

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23s

Nome

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Pages 1 and 2 should be filed within nent of Health and Montal Hygiere ant if item 27 is marked other than " ury or other traumetic event, the Mes

Department of Important: If any Injury or 2008.

Physician /Medical

Examiner

21215-0020

Baitimore, Maryland

Directo

Funeral

2

Completed

Be

Physician/Medical by Completed

within 24 hours after death. To the Funeral Director: A To the Hospital completely

8

State Registrar

**DHMH 16 Rev 6/95** 

SEP 1 8 2000

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signeture end title of certifier

J BOLANDS MEADE, MD BOLANOS MEADE, MD

P13915

29c. License number UPRN#

1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

29d. Dete signed (Month, Day, Year) 09-14-00

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

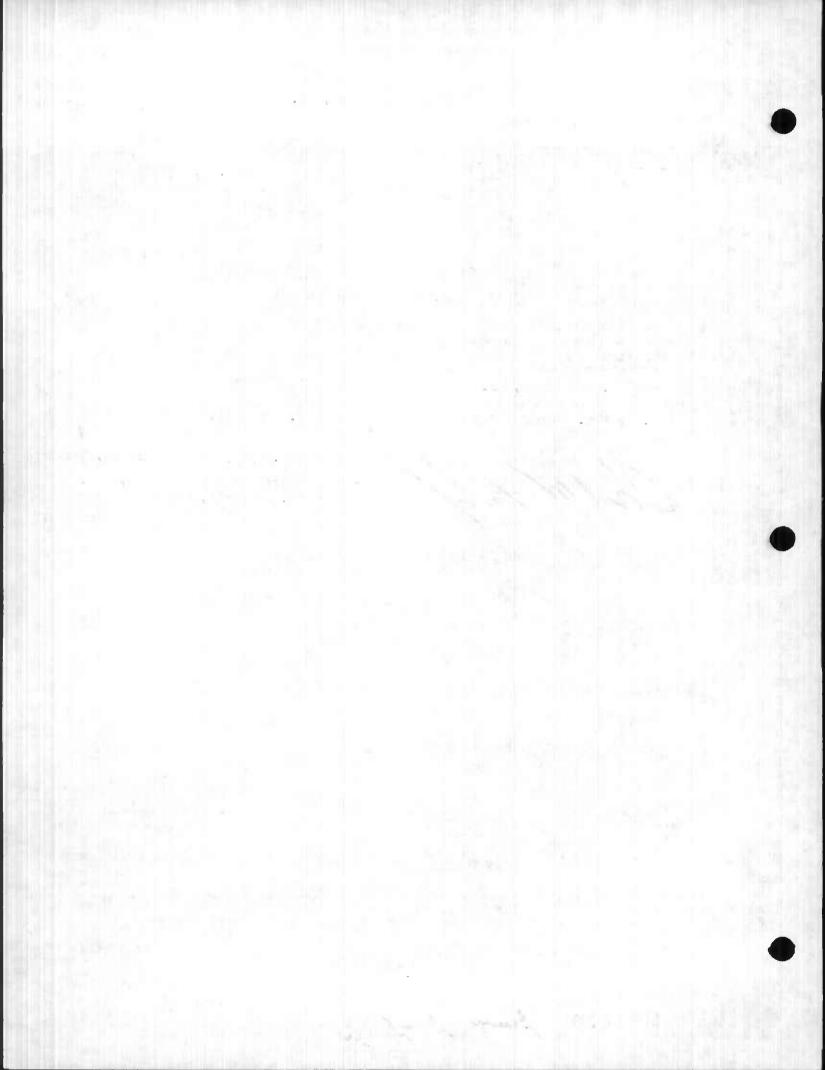
BVAMC 10 N GREENE, BALTIMORE MD 21201

31. Data filed (Month, Day, Year) 32. Registrar's Signature

6 Could not be

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

**ORIGINAL** 



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER 4, 2000 **Physician** 5:55 PM JAMES H. HEALY /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Elizabeth Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Days Hours Yrs. 217-14-1628 85 Director Aug 29, 1915 Usual Residence of Decedent 10a State 10b. Counts 10c. City. Town or Location 10d. Inside City Limits r 28a-f show MD N/A Baltimore 1X Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? "naturel", or items 23a or 3320 Benson Avenue 21227 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1Å Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d Deciment of Heelth and Mental Hygiene. Important: If item 27 is marked other than "naturel", or item in hillury or other traumatic event, the Medical Era winer. 1 Never Married 2 ☐ Married Specify: white 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 4 college professor education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James. P. Healy Anna L. Cooney 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) George Healy/brother 1055 W. Joppa Rd Baltimore, MD 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □ Burial 2 □ Cremetion 3 □ Removel from Stete 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee Oseph Van Sant State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201
Faul . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. interval Between Onset and Deeth Physician the mcluster condiovascular disease Immediate Cause (Final disease or condition resulting In death) /Medical Examiner Denieu Ha Examiner 5 years Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 Yes 2N No 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

that the death certificate be executed physiclen end s the burial-transit Division of Vital Records, P.O. Box 68760, signed by the e certificate has b irector, page 2 s Attending Physician: funeral death. after death Director: A 1 in by the fi e Hospital o 24 hours afi Funeral Di letely filled in

the Marylend

death

To Certification: Medical

1□Yes 21 No 27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident

3 Suicide

4 Homicide

29a. Certifier (Check only one)

6 Could not be determined

28a. Dete of Injury (Month, Day Year)

end menner state

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 10 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28b. Time of

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

28d. Describe how Injury occurred

29b. Signature end title of certifier

29c. License number

29d. Date signed (Month, Day, Year) Q 0052746 Sept, 12, 2000

30. Name and address of parson who completed cause of deeth (Item 23a) (Type, Print) Yelena I, pnik, 720 Maiden Choice lane, Salhiune 21228 31. Dete filed (Month, Day, Year)

Registrar

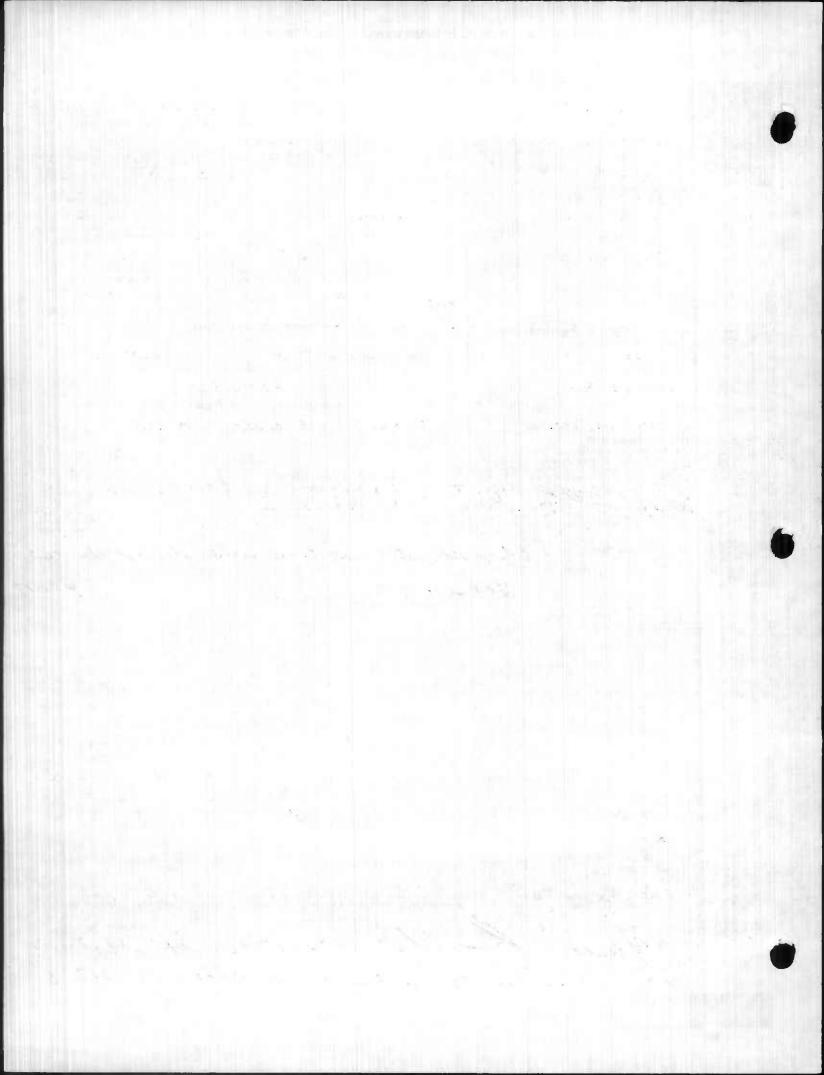
SEP 1 8 2000

32. Registrar's Signeture Geneva



**DHMH 16 Rev 6/95** 

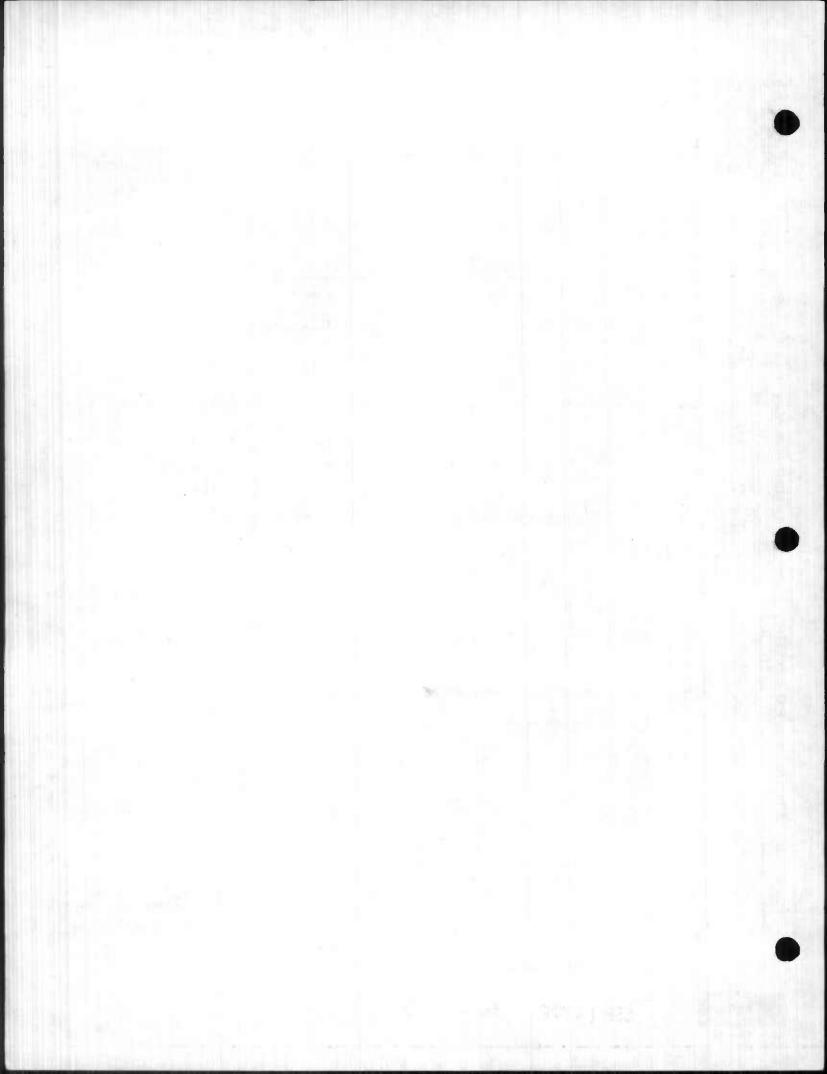
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State of Maryland / Department of Health and Mental Hygiene

	1. Dece	5-19B dent's Nam	ne (First, Midd						te of		2. Date of D Month	Reg. No. eath Day	Year	3. Tima of Death
ian ical	Tin	othy	Tyrone	Jef	ferson						July	19	2000	7:10 p.m
ner	4a Faci	ity Name (/	If not institution	on, give st	reet and numbe	r)				4b. City, Town, or	Location of Dea		nty of Death	
	Si	nai F	Hospita	al					1	Baltimore	e City			
		Security N	Vumber	8. Sex	M 2□ F	Age (In yrs	. last birthday) Yrs.	Months 0	Days 0			irth lay, Year) ,2000	9. Birth Cou MARYI	
	Usual R	esidence of	Decedent			10. 0	. 7							
_	10a. Sta		10b. County			10c. C	ity, Town or Loc							1 ☐ Yes 2 ☑ No
DC1C	MARY		RANDAL	LSTOW	N		BALTIMO	_						47
Director		eet and Nur						10f. Z	p Code			10g. Citizen	of What Cou	ntry?
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	1[]		ied 2 Mar	rried	2. Was Deceder Armed Force: 1 Yes 2 tribute Yes, Give Year or Dates	s? XNo			2 No	tispanic Origin? (\$ an, Mexican, Puer Specity:	to Rican, etc.)		Black, White,	etc.
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	17. Fath		(First, Middle,							18. Mothar's Na		e, Maidan Sun	iama)	
1					EFFERSON						A WHITE			
	19a. Inf	ormant's Na	ame/Relations	ship (Typ	e, Print)		19b. Mailin	g Addres	is (Street	and Number or R	ural Route Num	ber, City or To	wn, State, Zip	Code)
			ITE ( MO	THER	)		5432 (			ROAD RANI	DALLSTOWN			
	1 0	thod of Disp	Cremation	3 □8e	movel from Stat		Place of Dispos cemetary, crem	sition (Na natory or	ıma of other pla	ce)	Date		on - City or To	
-	4 🗆	Donation	5 Other (S	Specify)	HSP. DISP	OSAL	SINA	( )	108	P	7-216	POP	chie	mD 2121
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Examiner	Sequen	tially list co	enditions.	<b>b</b> .			or as a consequence or a consequence or a consequen		N M				1	
if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events														
	resoning	resulting in death) Last  d.										1		
	Port II C	ther elenit	licent conditi	one contr	ibuting to death	but not ro	rulting in the un	dorhána	onueo oi	on in Part I	23h Die	I tohacco usa	contribute t	o the cause of death?
ı	Part II. C	uner argent	ream conditi	OHE CON	iboting to death	DUI NOT 19:	soming in the tri	ioenying	cause gr	ven in Fatt I.				bably 4 X Unknow
١														
											24a. Wa	s an autopsy lomed?	av cc	are autopsy lindings railable prior to empletion of cause death?
													<i>y</i>	☐ Yas 2 🖾 No
											1	Yes 2KDN	1	1 1 42 5 5 140
-	25. Was	case refer	red to medica	nl						26. Place of De	ath (Check only		1	
	exar	case refer niner? Yes 2🔯		-	spitat:	tient 2	] ER/Outpatient	3□ 0	OA Ott	200		ona)		
	exar 1 🗆 27. Mani	niner? Yes 2⊠ ner of Deat	No h	Ho	1 LX Inpa		28b. Time of	3□ [	28c. Inju	ner: 4□ Nursing I ry at	ath <i>(Check only</i> Home 5 Res	ona)	Other (Speci	
	27. Mani	niner? Yes 2⊠	h 5 Pendii Investi	ng igation	spitat: 1 🕱 Inpa 28a. Date of In (Month, L	jury Jay Year)	1	3 D	28c. Inju	ner: 4 Nursing I	ath <i>(Check only</i> Home 5 Res	ona) sidence 6	Other (Speci	
	27. Mani 1 27. Mani 2 2 3	niner? Yes 2\(\bar{Q}\) ner of Death Natural	No h 5 ☐ Pendii	ng igation not be	28a. Date of In (Month, D	jury lay Year) A	28b. Time of Injury	м	28c. Inju Wo 1 □	ner: 4□ Nursing I ry at	eath (Check only) Home 5 Rec 28d. Describe N/A 28f. Location City or To	ona) sidence 6 D how Injury oc	Other (Speci	
continuation. To be completed by	9xar 1 27. Manu 1 2 3 3 4 4	niner? Yes 2  ner of Death Natural Accident Suicide Homicide	h 5 Pendii investi 6 Could determ	ng igation not be nined	28a. Date of In (Month, I N/ 28a. Place of it building, it	jury lay Year) A njury - At h atc. (Speci N/A t of my kno of examina	28b. Time of Injury N/a nome, farm, stre	M set, facto	28c. Inju Wo 1	ner: 4□ Nursing I ry at	ath (Check only Home 5 Res 28d. Describe N/A 28f. Location City or To	ona)  sidence 6 in how Injury och  (Street and Nown, State)  N/A  a causa(s) and	Other (Special curred sumber or Runner as a	al Route Number,
ocical certification. To be completed by	9xar 1 27. Manu 1 2 2 3 3 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	niner? Yes 2 \( \bar{\sigma} \) ner of Death Natural Accident Suicide Homicide rtifier eck only	h 5 Pendii investi 6 Could determ	ng igation not be nined	28a. Date of in (Month, E) 28a. Place of i building, i building, i clan: To tha besir: On the basis	jury lay Year) A njury - At h atc. (Speci N/A t of my kno of examina	28b. Time of Injury N/a nome, farm, stre	M occurred astigatio	28c. Inju Wo 1 □ ry, office	ner: 4 Nursing I	ath (Check only Home 5 Res 28d. Describe N/A 28f. Location City or To	ona)  sidence 6 in how Injury och  (Street and Nown, State)  N/A  a causa(s) and	Other (Special curred sumber or Runner as a ce, and dua to content to content to ce, and dua to	al Route Number, stated. o tha cause(s)
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Medical Certification: To Be Completed by Physician/M	exar 1 27. Man 1 23 29a. Ce 29a. Ce 20b. Sig	niner? Yes 2 1 Death Natural Accident Suicide Homicide rtifier eck only	No  h 5 Pendii investi 6 Could detem  1X Certifyir 2 Medical	ng igation not be nined Examine	28a. Date of in (Month, E) 28a. Place of i building, i building, i clan: To tha besir: On the basis	jury lay Year)  A njury - At h atc. (Speci N/A t of my love of examinated.	28b. Time of Injury N/a  N/a  Nome, farm, stre fy)  owledge, death atton and/or inv	M  occurred astigation  29  In Print) (	28c. Injune 28c. Injune 28c. Injune 28c. Injune 28c. Injune 28c. Injune 28c. Injune 28c. License 22399	ner: 4 Nursing I ny at rk? I Yes 2 No me, data and place opinion, daath occur se number	ath (Check only Home 5 Ret 28d. Describe N/A 28f. Location City or To	ona) sidence 6 to how Injury oc (Street and Nown, State) N/A a causa(s) and d, data and place	Other (Special curred sumber or Runner as a ce, and dua to gned (Month,	al Route Number, stated. o tha cause(s)  Day, Year)



State of Maryland / Department of Health and Mental Hygiene AMEND ITEMS: #23 PART I, 27, 28A-F Certificate of Death

Baltimore Maryland 21215-0020  ath certificate be executed the property and 2 should be filed within 72 hours after death with the Maryland Language and Language		
Baltimore, Maryland 21215-0020  remit Paper 1 and 2 should be filed within 72 hours after death with the Maryland Department of teath h and Mental Hygiene. Important if them 27 is marked other than "natural", or items 23e or 28e-f show any indury or other traumstic event, its Marked Engineer must be morthed at 10.  To Be Completed by Funeral Director	/Medical	1. 4a
Baltimore, Maryland 21215-0020  From Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health And Mental Hygiene.  Important if them 27 is marked other than "natural", or items 23e or 28s-1 show any indury or other traumatic event, the Maryland pages.  To Be Completed by Funeral Director	Funeral Director	5. 5
Physician /Medical Examiner	2	
Physician /Medical Examiner	Marylar la-f show ut sol	10
Physician /Medical Examiner	h with the	10
Physician /Medical Examiner	0020 nours after deat rest, or terms 2	11.
Physician /Medical Examiner	n 72 h	
Physician /Medical Examiner	212 d withing and	'
Physician /Medical Examiner	land id be file fental Hy ked othe dc event,	17.
Physician /Medical Examiner	Mary 42 shou h and N	19
Physician /Medical Examiner	Nore, ges 1 and 11 of Heal If New 2 or other	200
/Medical Im dis res	Baltim permit. Pa Departmen Important: any follory once.	21
/Medical Imdia	<b>ENGINE</b>	23
Sox 68760, th certificate be executed ending physician and r use as the burial-transit an/Medical Examin	/Medical Examiner	Im dis res
	tox 68760, th certificate be executed ending physician and ruse as the burial-transit an/Medical Examin-	Se if a ca Ca tha

detached

2

2

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has page 2

this certificate

P.O

of Vital Records,

Division

Hospital 24 hours

To the I within 2

The law requires that the

Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year AUGUST 21, 2000 ERIC JONES 11:31 P.M. 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Deeth PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY If Under 1 Yeer | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Mar 28, 1971 Birthplace (State or Foreign Country) Country) 1 X M 2 □ F Months Days Houra 29 UNK ual Residence of Decedent 10c. City. Town or Location a. State 10b. County 10d Inside City Limits Prince Georges Capitol Heights 1 Yes 2 No e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5402 Dole Street 20743 USA Merital Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify: black unk 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk unk Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e. Informant's Name/Reletionship (Type, Print) O.C.M.E. 111 Penn Street Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, cremetory or other place) a. Method of Disposition 20c. Location - City or Town, Stete Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 MOther (Specify) in State in state Signature of Funeral Service Licer Joseph B. 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 See Pain . Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth nmediate Cause (Final sease or condition sulting In death) NARCOTIC INTOXICATION Due to (or as a consequence of) equentially list conditions, any, leeding to immediate suse. Enter Underlying ause (Disease or Injury at initiated events sulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Physic Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably Completed by 24b. Were autopsy findings evallable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Nos 2 No 1 Yes 2 No ai or Attending Physician: The safter death.

I Director: After this certificated in by the funeral director, pa Be 25. Was case referred to medicel examiner? 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Y☐ Yes 2☐ No Medical Certification: To 28a. Date of Injury g\_(Month\_(ray)(rear) FOUND: 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred P Found: 1 Natural 5 Pending 1 Yes 2 No UNKNOWN investigation 2 Accident Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number City or Town, Stete) 5402 DOLE S 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND: RESIDENCE 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basic of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. AUGUST 21,2000 na, Person who completed cause of death (Item 23e) (Type, Print)
Penn Street, Baltimore, Maryland 21201 30. Neme and address of MARY G. RIPPLE, MO.

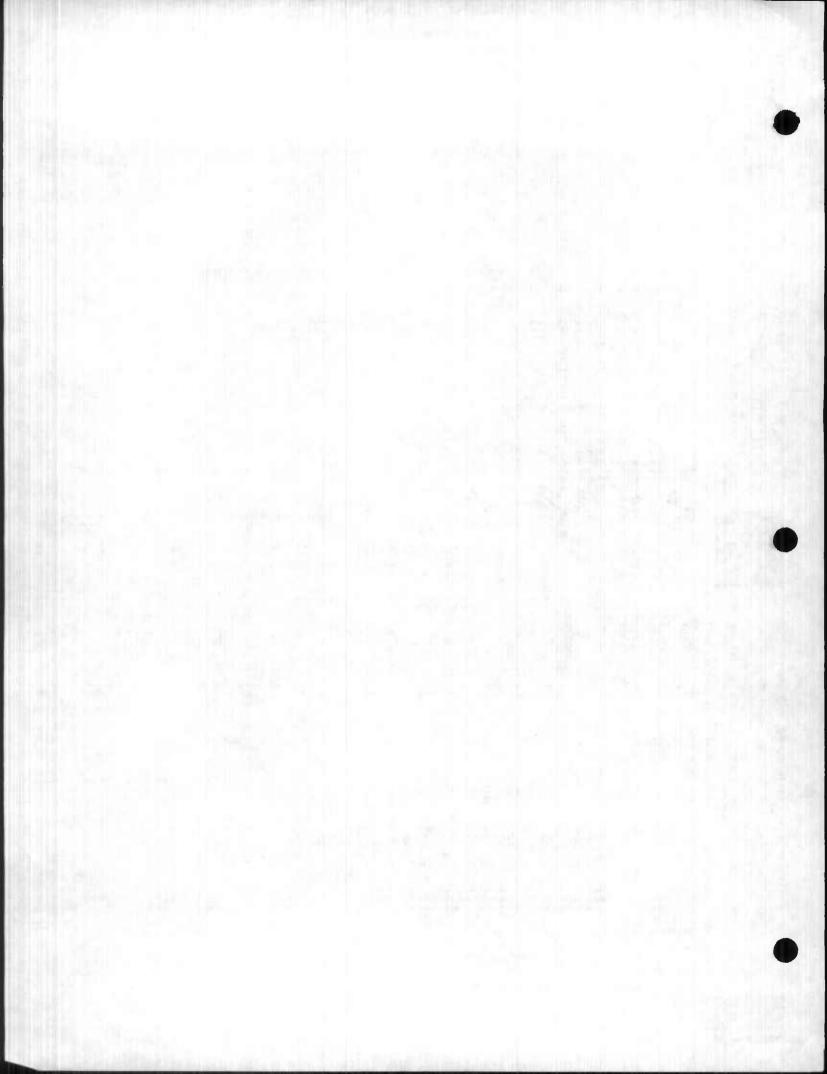
Registrar

31. Date filed (Month, Dey, SEP

oacto

32. Registrar's Signature

Roser



State of Maryland / Department of Health and Mental Hygiene 11 2931.1.

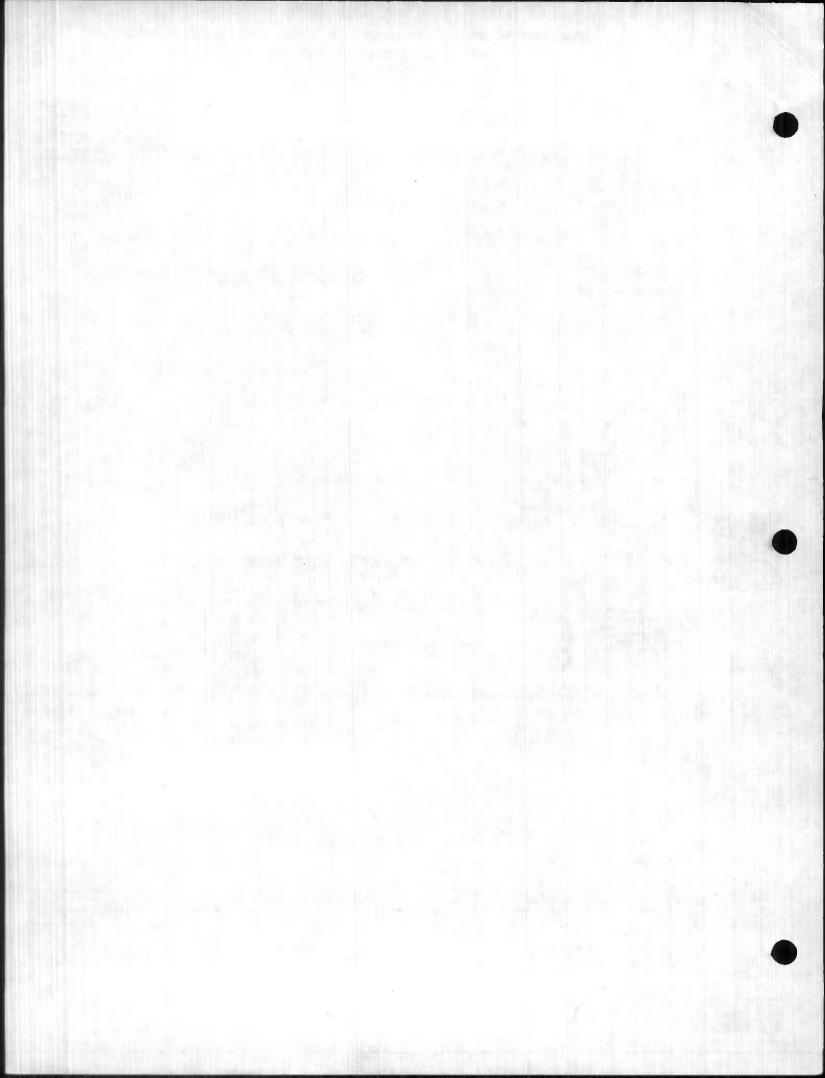
						Ce	rtificat	te of	Death			Reg. No.		2 2 3 4 4
Physic /Med		1. Decedent's Name (Fit TAYLOR FA)									2. Date of De Month SEPTEME	Day	Year 2000	3. Time of Death 4:15 a.m.
Exam		4a Facility Neme (If not FRANKLIN S				PENTE	R		0	m, or Lo	cation of Death	4c. County		DRE
Funera Directo		5. Sociel Security Numb				last birthday) Yrs.		r 1 Yeer Deys	If Under 2 Hours	Min.	8. Dete of Bird (Month, Da	y, Year)	9. Birthp Cour	olace (State or Foreign ntry) MD
P	•	Usual Residence of Dec												
with the Maryland a or 28a-f show	ctor	10a. State 10t	.County Harford		10c. Ci	Falls	ton							1 ☐ Yes 2 🛣 No
h with the	Funeral Director	10e. Street and Number 2802 Cross		y Ct			10f. Zip	Code 21	047			10g. Citizen of \	What Coul	ntry?
5-0020 72 hours after death	by Funer	11. Meritel Status  1 X Never Married  3 Widowed 4		12. Wes Decede Armed Force 1  Yes 2 if Yes, Give Yeer or Dete	is? ∑No				lispanic Orig en, Mexican, Specify:	in? (Spe Puerto	cify Yes or No Rican, etc.)	14. Rac Bled Specify	a - Americ ck, White,	can Indian, etc.
T 8 2	Be Completed	15. (Specify of Elementary/Secondar	Decedent's Edu	ucation de completed) College (1-4	05.64	16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	at Occup ork done ise retire	etion during most d)	of worki	ng	16b. Kind of B	usiness/In	dustry
2121 d within giene.	E	0	y (0-12)	College (1-4	0		non	e				n	one	
Maryland 2 d 2 should be filed th and Mental Hygin 7 ie marked other treumatic svent, it	3e C	17. Father's Name (First	, Middle, Last)		100	COST	3.1	134	18. Mother	's Name	(First, Middle,	Maiden Surnan	10)	
ylan buid be Mental arked o	To	Michael Ha	armon						Dawr	ne Ja	acobs			
Taryla 2 should and Mer in marks		19a. Informant's Name/				19b. Maili	ng Addres	s (Street	and Numbe	r or Aura	I Route Number	er, City or Town,	State, Zip	Code)
CZNL		Franklin So	quar Hos	spital					n Squa	re I	Orive	Baltimo	re, M	D 21237
altimore,		20a. Method of Dispositi 1 Buriel 2 Cr. 4 Donation 5 D	emetion 3 🔲			Piace of Dispo cem <i>etery, cre</i> i	natory or	me of other pla	ce)	i	Dete	20c. Location -	City or To	own, State
Balt permit. Depart imports any inju		21. Signeture of Eunera J OS	Service Licens	Van Sant		22			a for Fecility a formy	Boar 21		W. Bal	timor	re Street
Physician /Medica Examine		Immediate Ceuse (Fine disease or condition resulting in death)			comp	ATABI	117	Y				rrest,		Approximate Interval Between Onset and Death
				/	Due to (	or as a conse	quence of)	:						
De ist	nin			b	REMI	OF AS A CONSE	TY						i	
68760, ifficate be executed g physician and as the burial-transit	edical Examine	Sequentially list condition if any, leading to immediate. Enter Underlying Cause (Disease or injurithat initiated events	ons, liate	G	Due to (	or as a consec	quence of)	:						
	-	that initiated events resulting in death) Last	311	d	Due to (d	or as a consec	uence of):							
P.O. hat the dd by the detached	Physician/N	Pert II. Other algnificant	t conditions co	ntributing to deat	h but not res	sulting in the u	nderlying	cause gi	ven in Part 1.			tobacco uas co		o the cause of death?
COLC requir	Completed by											en eutopsy ormed?	8/	fere autopsy findings vailable prior to empletion of cause death?
I Rec The law ate has t	J. L										103	Yes 2010		Yes 2 No
Vital I		25. Was case referred to	o medical						00 01	-4 04	10			1 165 20 140
of Vita Physician: this certific	o Be	axaminer?	+	Hospital	-tit 05	1 ED/O-4		On Oth	oer:		(Check only		(0	4.1
Phys ral dis	To To	27. Manner of Death		28a. Date of (Month,		28b. Time o		28c. Inju Wo	4LI NU			dence 6 Oth		ry)
Division or Attending I after death. Director: After	Certification:	2 Accident	Pending investigation Could not be			Injury	M	10	rk?  Yes 2∐I		29f Location /	Street and Num	her or Pur	al Pouta Number
DIVISION HOSPITAL OF ATTENDED SET HOURS AFFOR THE CHART OF FUNCTION HOSPITAL OF THE CHART FILLED IN DESTREE THE CH	Certif	4  Homicide	determined	building	etc. (Speci						City or To	wn, State)		al Route Number,
the Hospital in 24 hours a the Funeral i	ledical	29a. Certifier (Check only 2 one)	Certifying Phy Medical Exami	reician: To the be fner: On the basi end manner	s of examine	owledge, deat ation and/or in	occurred vestigation	et the ti	me, date end opinion, daat	d place, a	and due to the ed at the time,	cause(s) and m date and place,	anner as : and due t	stated. to the cause(s)

State Registrar

who completed cause of death (Item 23a) (Type, Print)

RD 192856

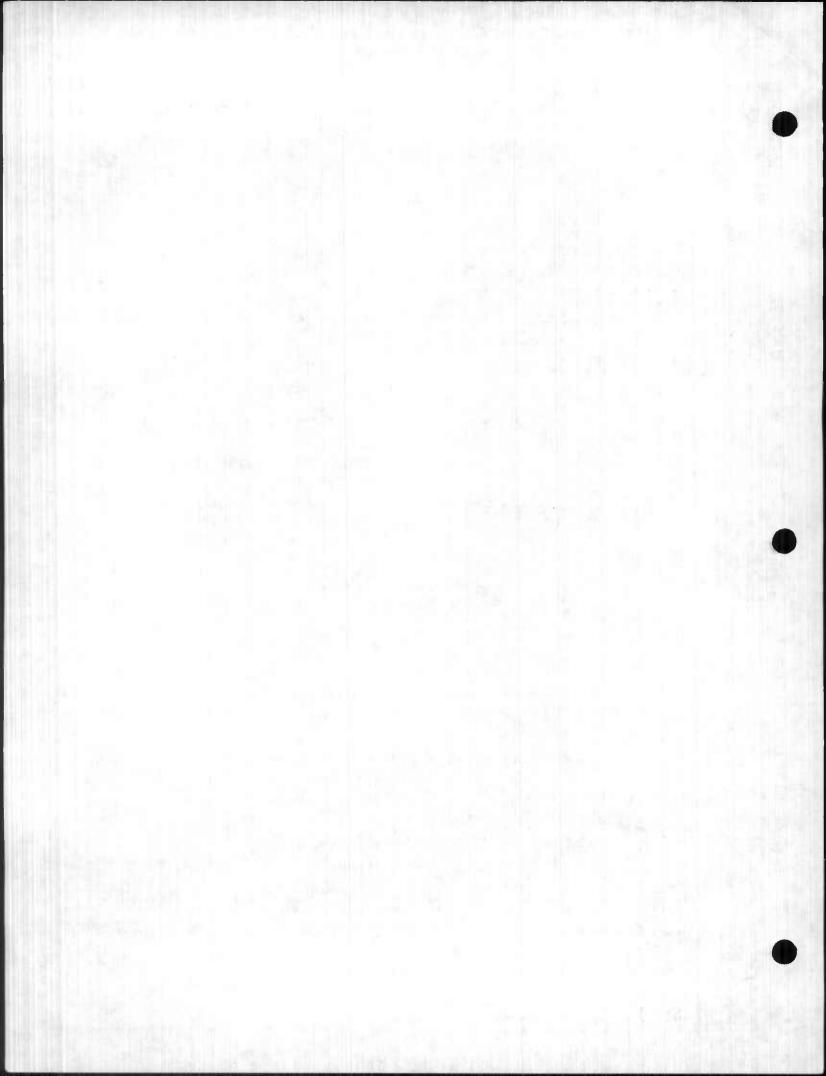
LACOUR, MD. 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237



	Decedent's Name (First, Mi	ddle Leet		40	Cei	rtifica	te of	Death	2. Date of D	Reg. No.	lon	. 9 3 4 5
Physician									Month	Day	Year	4 50
/Medical	JAMES JONES  4a Facility Name (If not institu		street and number					4b. City, Town, o	SEPT or Location of Dea	1.5, ath 4c. Coun	2000 ty of Death	11300111
Examiner	STELLA MORE				LANEY	)		TIMONI			LTIM	ORE
Funeral	5. Social Security Number	6. Sex	7. A		last birthday)	•	or 1 Year Days		rs. 8. Date of B			place (State or Foreign
Director	265-38-0630	115	XM 2□ F	72	Yrs.	WIOTHITE	Days	Tiours (Wi	05-23			A
Pu k	Usuat Residence of Decedent 10a, State 10b, Cou	ntv		10c. Cit	ty, Town or Lo	cation					1	10d. Inside City Limits
72 hours after death with the Maryland natural, or items 23s or 28s-f show offer Examiner must be notified at sted by Funeral Director			Λ.			LTO						15 Yes 2□No
r from 23a or 28a-fa nine matte notified Funeral Director	MD 10e, Street and Number	N/Z	A		DA	-	ip Code			10g. Citizen of	What Cour	ntry?
3a or		<b>УШ</b> СГ						21207		77 0		in artisti
Hema 2	6507 LEHNEI		12. Was Decedent	Ever in U	,S. 13.	Was Dec	edent of I		(Specify Yes or North Rican, etc.)		A .	
by by	1 Never Married 2 Nover 3 Widowed 4 Divorce		Armed Forces  1 Yes 2  H Yes, Give  Year or Dates:			1 ☐ Yes	v	Specify:	ento Pican, etc.)	Spec	ack, White,	BLACK
than "natural", he Medical Ex- ompleted by		lent's Educ			16a. Dece	dent's Us	uai Occup	pation during most of w	endrina	16b. Kind of	Business/In	dustry
completed	(Specify only hig Elementary/Secondary (0-1)	-	College (1-4or	5+)	life.	DO NOT	use retire	d)				
	8th	#= # = · · ·			DO	ORM	AN	10 Mark	amo (Final Adia)			CASINO
Be	17. Father's Name (First, Midd								ame (First, Midd		HI10/	
J.	OLLIE JONES		no Brint		105 14-77	no Adda	100-		RINE CU		n State 7:-	n Code)
200	19a. Informant's Name/Relation		pe, Print)						Rural Route Num			
other	ADA JONES, I	WIFE		20b. I	Pieca of Dispo	sition (N	eme of		BALTIM	ORE, MI 20c. Location	2 ] - City or To	207 own, State
- Source	1 Burlal 2 ☐ Crematic		emoval from State		cemetery, cre	natory or	other pla					
4	4 ☐ Donation 5 ☐ Other 21. Signature 1 5 rv		. /	AR				AL PK	9-21-0	UO ARI	BUTUS	s, MD
buce	23a. Part1. Enter the disease shock, or heart failure. I	11	1		H	OWE	T.T. F	TINERAL	HOME			
s the buna-transit and incal incal examiner	Immediate Cause (Finat disease or condition resulting in death)  Sequentially list conditions,		LUNG (	Due to (	R or as e conse							
edicai	if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	1		Due to (d	or as a consec	quence of	):					
Physician/M												
/ Physician/N	Part II. Other significant cond	litions con	tributing to death I	out not res	sulting in the u	nderlying	cause gi	iven in Pert I.				to the cause of death?
by Ph									1[	Yes 2 No	3 Pro	bebly 4 \(\times\) Unknown
Completed by P						4				as an autopsy normed?	av CC	Vere autopsy lindings vallable prior to ompletion of cause death?
отр									4.0	Yes 2X No		Yes 2 No
	25. Was case relerred to med	ical						26 Place of F	Death (Check onl			_ 100 2010
To Be	examiner?	-	lospitat:	ent 2	ER/Outpatie	nt 3 🗆 t	OOA O	her	Home 5 Re		Other (Speci	iv). HOSPICE
	27. Manner of Death 1 ☑ Neturet 5 ☐ Per	nding estigation	28a. Date of Inj (Month, De	ury	28b. Time of injury		28c. Inju		-	e how injury occ		W HUSPICE
Certification:	3 ☐ Suicide 6 ☐ Cou	ald not be ermined	28e. Place of the building, e			reet, facto	ory, office		28I. Location City or 1	(Street and Nu Town, State)	mber or Rur	rel Route Number,
Medical Cert			nician: To the best ner: On the basis of and manner s	of examine								
Medical Certificat	29b. Signature and title of carl	ilier				2	_	se number	_	29d. Date sig	ned (Month,	, Day, Year)
IV		12	-				DL	13725	100	9	1151	w.
m	DO. Name and address of pers	on who co	mpleted cause of	death (Ite	m 23a) (Type,	Print)						
MA	DR. TARIQ M				NEY VA		RD.	TIMONI	UM, MD	21093		
State	31. Date liled (Month, Day, Ye	ar)	32. Regist	rar's Sign	ature		,					
Registrar	SEP 162	000	100	man	1	-	1- 4	F 1				



State of Maryland / Department of Health and Mental Hygiene 29346 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Da **Physician** SEPTEMBER 13, 2000 ROZA KHARLAF 7:40 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner 7080 CRADLE ROCK WAY #720 CCLUMBIA HOWARD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Pay, Year) JUN. 16, 1931 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Months Days Hours 1 M 2 F 69 Yrs. RUSSIA 216-37-7764 **Director** Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No HOWARD 28a-f Directo COLUMBIA 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code mant he n 7080 CRADLE ROCK WAY #720 21045 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, atc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Yeer or Dates: 1 Never Merried 2 Married b Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. À WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry fllad within Elementary/Secondary (0-12) College (1-4or 5+) Hygiera. 4 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) . Pages 1 and 2 should be fill ment of Health and Mental H tant. If hem 27 is marked off jury or other traumatic even Be **EVSEY** KAZAKEVICH FAINA (UNKNOWN) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) NATALIE SMOLYAK / DAUGHTER 7223 DOCKSIDE LANE - COLUMBIA, MD 21045 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CCLUMBIA MEMORIAL PARK 9/15/00 COLUMBIA, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SCL LEVINSON & BROS., INC. roter 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) BREAST CANCER 7 YEARS Examiner Due to (or as a consequence of) Physician/Medical Examiner HYPERTENSION 15 YEARS g physician and as the bunal-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequenca of): 68760. thet initieted events resulting in death) Last Due to (or as e consequence of): Box P.O. 23b. Did tobacco use contribute to the cause of death? detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. á 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown p Records. 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 1 ☐ Yes 2 ☒ No 1 Yes 2 No of Vital Physician: Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending F Division 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident Director 3 Suicide 6 Could not be determined 281. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date end pleca, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated. edicai 29a. Certifier 29b. Signature and title of cartified 29d. Date signed (Month, Day, Year) 29c. License number D50184 SEPT. 14, 2000 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) ELLICOTT CITY, MD 21042 ZHANNA KALIKHMAN 9501 OLD ANNAPOLIS ROAD 31. Date liled (Month, Day, Year) 32. Registrar's Signature State 1 8 2000 oaks Registrar



10f. Zip Code

1 Yas 2 No Specify:

16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired)

housewife

State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death SEPTEMBER 3, 2000 IMMIGENE N. LAIRD 2:55 AM 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4909 Eastern Avenue Baltimore N/A If Under 1 Year | if Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1□M 2X F Months Days Hours Min Yrs. 76 PA 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore 1X Yes 2 No

21224

13. Was Decedent of Hispenic Origin? (Specify Yas or Noif Yes, specify Cuban, Maxican, Puarto Rican, etc.)

10g. Citizen of What Country?

16b. Kind of Buainess/Industry

18. Mother's Neme (First, Middla, Meiden Surnema)

1 Yas 2 No

28d. Describe how injury occurred

5 Residence 6 □Other (Specify)

GSRIDRICS CTZ

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29d. Data signed (Month, Dey, Year)

26. Place of Deeth (Check only one)

Other: 4 Nursing Home

1 Yes 2 No

28c. Injury et Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and menner as stated.

Johns Hopkins

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and menner stated.

29c. Licansa number

5505

1 ☐ Yas 2 ☐ No

21224

Laura M. Renshaw

USA 14. Race - American Indian,

none

white

Bleck, White, atc.

**Funeral** Director

**Physician** 

/Medical

Examiner

5 Social Sacurity Number

Usuai Residence of Decedent

10b. County

4909 Eastern Avenue

15. Decedent's Education (Specify only highest grade completed)

1 □ Never Married 2 □ Married

3 Widowed 4 □ Divorced

Elementery/Secondery (0-12)

17. Fether's Name (First, Middle, Last)

Carroll O. Nailer

12

12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yas, Giva Yaar or Dates:

College (1-4or 5+)

0

220-22-9515

10e. Street end Number

10a State

Director

Funeral

ρλ

Completed

MD

the Manyland with death 72 hours after Illed within 7 Hygiena.

7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Modical Examinar must be notified at permit. Pages 1 and 2 should be file.
Department of Histility and Mental Hy.
Throcottant: If item 27 is marked other
any injury or other traumatic event,

Maryland 21215-0020

Baltimore,

Box 68760.

o.

Δ.

Division of Vital Records.

Physician /Medical Examiner

Examiner

Physician/Medicai

by

Completed

Be

P

Certification:

Medical

25. Was case referred to medical examiner?

29b. Signature end itle of certifier

31. Date filed (Month, Dey, Year)

5 Pending

investigation

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

John R BURTUH MD Johns H

6 Could not be

SEP 1 8 2000

1 Yes a No

27. Manne of Deeth

2 Accident

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

that the death certificate be axecuted and physician s the burial 88 ed by the a signed by t law requires should | certificate has The after death.

Director: After this certifications funeral To the Hospital or Atter within 24 hours after des To the Funeral Director completaly filled in by th

19a. informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) unk 20b. Place of Disposition (Neme of cematery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 Buriel 2 Cremetion 3 Removel from State
4 Donation 5 Other (Specify) 21. Signatura of Funeral Service Licensee Joseph 22. Name and Address of Fecility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Baltimore, MD 21201

23a. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death immediete Ceuse (Finel disease or condition resulting in deeth) Hapertic 1908 PU Carcinoma mo Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as a consequence of): 23b. Did tobacco use contributs to the causs of death? Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed?

1 Inpatient 2 ER/Outpatient 3 DOA

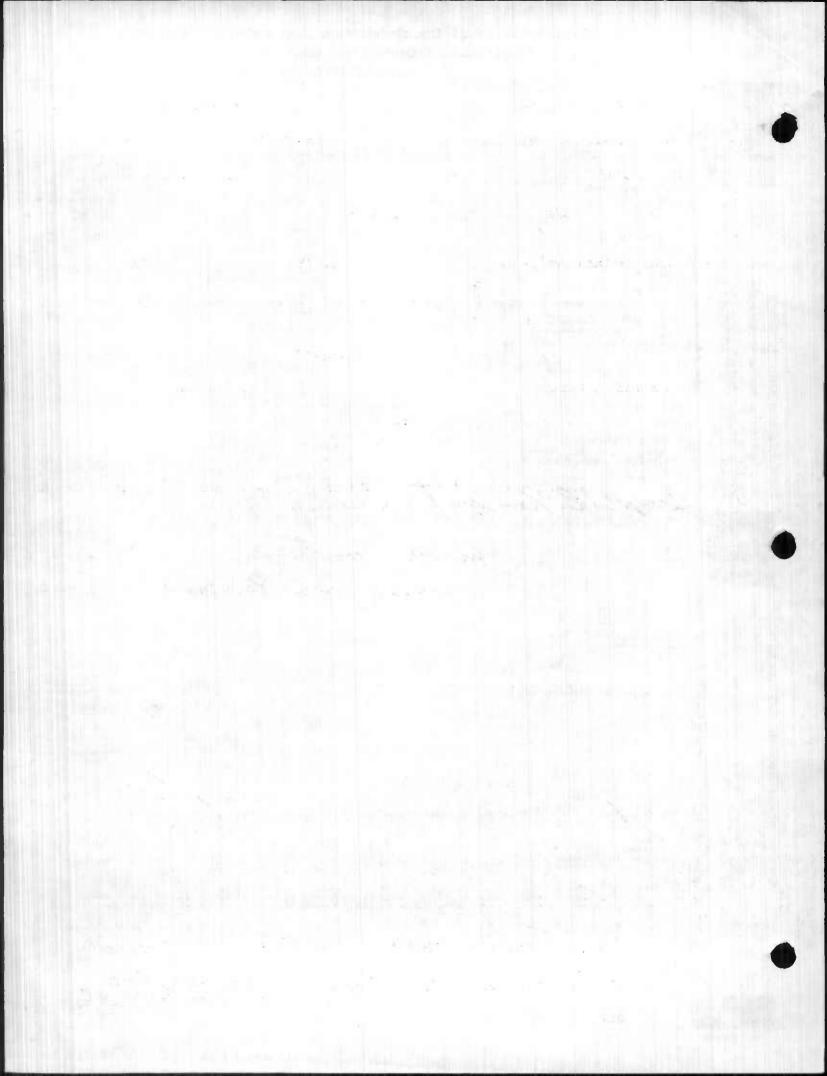
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28e. Dete of injury (Month, Dey Year)

32. Registrer's Signeture

28b. Time of

State Registrar



#### Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Month Dev SEPTEMBER 3, 2000 8:30 PM EDWARDO LOPEZ 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street and number) 8511 PERTH LANE CLINTON PRINCE GEORGES If Under 1 Yeer | If Under 24 Hrs. 5. Sociel Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dev. Year) 1MM 2□ F Deys Hours Min Yrs. 66 577-64-6997 July 7, 1934 Ecuador Usual Residence of Decedent 10e State 10c. City, Town or Location 10d. Inside City Limits MD Prince Georges Clinton 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8511 Perth Lane 20735 USA 14. Rece - American Indien. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: Spanish Specify: hispanic 3 ☐ Widowed 4 ☐ Divorced 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grede completed) Coilege (1-4or 5+) Elementery/Secondary (0-12) 12 0 bartender hotel 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Rafael Lopez Amaba Yanec 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Lilianna Carrillo/daughter 8511 Perth Lane Clinton, MD 20b. Plece of Disposition (Neme of cametery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name end Address of Facility Joseph B, Van 655 W. Baltimore Street State Anatomy Board Baltimore, MD 21201 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death immediate Cause (Finel MULTIPLE MYELOMA diseese or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of) 23b. Did tobacco use contribute to the ceuse of deeth? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown 24e. Wes an eutopsy

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

certificate be

The law requires that the dearn

or Attending Physicien:

Hospital

funeral

After t

n 24 hours after death.
The Funeral Director: After the further in by the further further the further

To the F Within 2 To the F

Certification:

Medical

3 ☐ Suicide

4 Homicide

31. Date filed (Month, Day, Year)

**Physician** 

/Medical

Director

Funerai

à

Completed

Examiner

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28s-f ahow traumatic event, the Magical Examinar mant be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene.
Important: If frem 27 is merked other than "natural", or freme 23a
mush injury or other traumatic event, the Medical

the Maryland

with

Examiner 먑 physician at a the butial-t Physician/Medical attending pt the signed by the Completed by been : page 2 hes certificate Be 10 this

24b. Were eutopsy findings evailable prior to completion of cause

1 □ Yes 2 No

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Deeth 28c. injury at Work? 1 Neturei 5 Pending 1 Yes 2 No 2□ Accident investigation 6 ☐ Could not be

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29b. Signeture end till o certifier 29d. Dete signed (Month, Day, Year) 29c. License number

30. Name end eddress of parson who completed cause of deeth (Item 23e) (Type, Print) L O U (  $\leq$  D (  $\not\in$  /+  $\subset$ JUITNS NCOLOGY HOPKINS CM

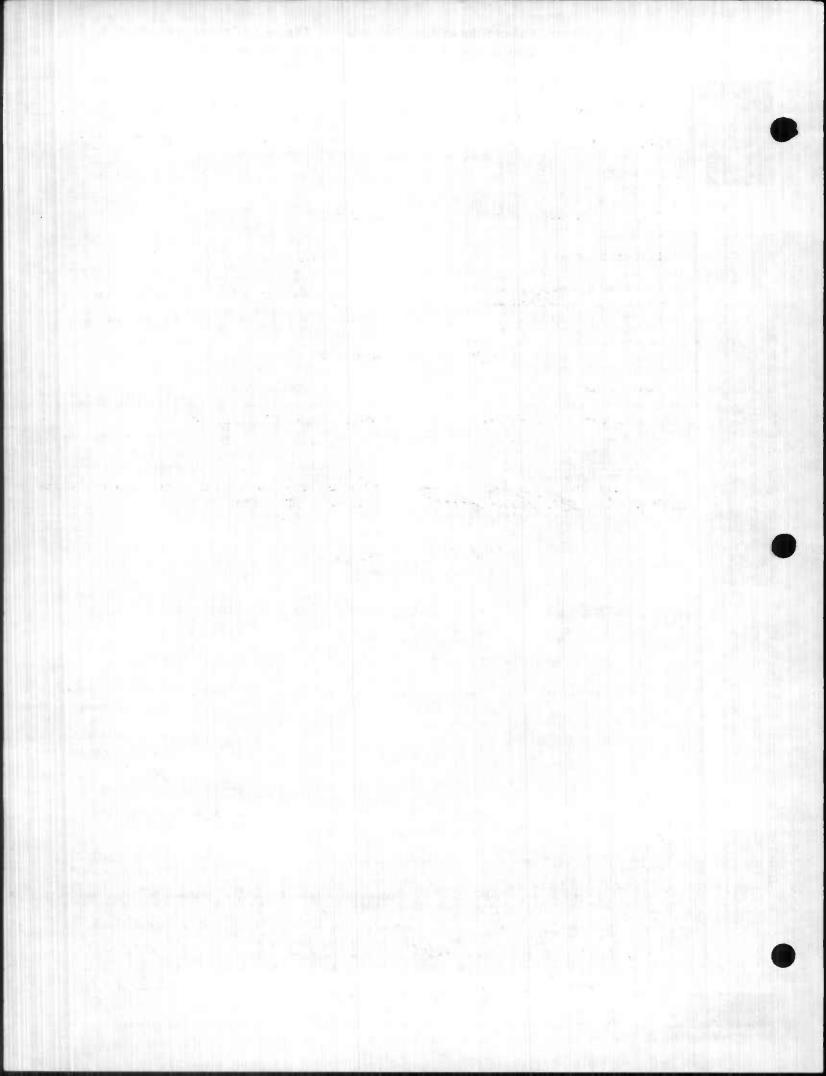
600 NONTH WULFE ST BALTIMORE MO

Registrar

1 8 2000







#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Dev ROSE H. LASKY SEPTEMBER 13, 2000 6:30 PM /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner KESWICK NURSING HOME BALTIMORE N/A 5. Social Security Number 213-48-0423 If Under 1 Year If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthpiece (State or Foreign Country) Funerai Deys 1□M 2X F Months Yrs Director 97 Dec 27, 1902 MD Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location show 10d. Inside City Limits 7 is marked other than "natural", or flems 23a or 28a-f show traumatic event, the Medical Examiner must be not fied at MD N/A Baltimore Director 17 Yes 2□No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 700 W. 40th Street 21211 Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2X No Completed by 3 ₩idowed 4 Divorced Specify: white 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 12 unk teacher education pemit. Peges 1 and 2 should be file Department of Heelth and Mental Hy important: If Nem 27 is marked oths any injury or other traumatic event. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Samuel Horwitz Lena Glick 19a. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Alfred Pasternak/godchild 6311 Herkos Ct Bethesda, MD 20817 20e. Method of Disposition 20b. Plece of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetion 5 □Other (Specify) 21. Signeture of Funerel Servica Licensee Joseph B. Van Sant 22. Neme end Address of Facility State Anatomy Board 655 W. Baltimore Street RB. Fai Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediete Ceuse (Final Dueumonia diseese or condition resulting in death) **Examiner** Due to (or es a consequenca of) Examiner The law requires that the death certificate be executed the buriel-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): ed by the ettending physicien deteched for use as the burle Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? is certificate has been signed by director, pege 2 should be detect 1 Yes 2 No 3 Probably 4 Unknown dementin py Completed 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Wes en eutopsy performed? this certificate has 1 ☐ Yes 2 ☐ No Physician: Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Rursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28c. Injury et Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of After Attending 5 Pending Investigation 1 Neturel death. 1 ☐ Yes 2 ☐ No 2 Accident or Attend effer death Director: 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours e Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner as stated. Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and pleca, and due to the ceuse(s) end menner stated. 29a. Certifier Medicai 296. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) 1 8 2000

BMQ 32. Registrar's Signeture

nd eddress of person who completed cayse of deeth (1)

N. Charles St. Balts. Md 21208 6701

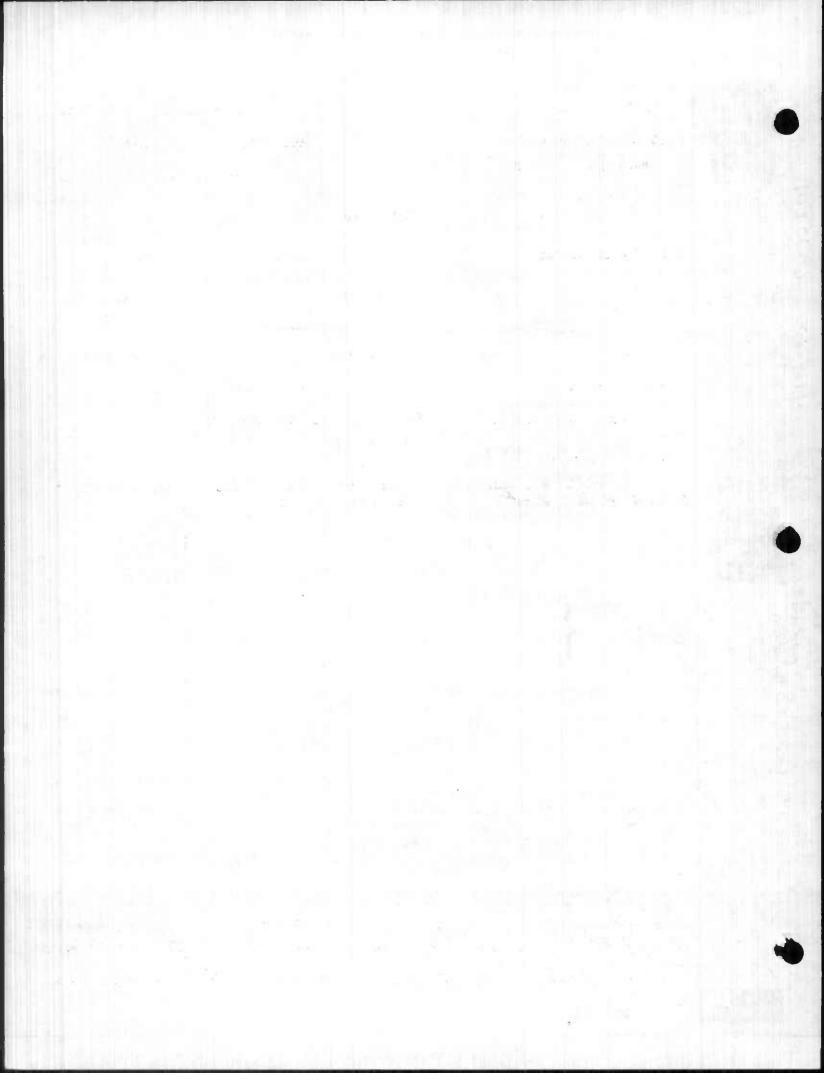
m 294) (Type, Print)

**DHMH 16 Rev 6/95** 

5/5

P.O. Box 68760,

Division of Vital Records.



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** 59 pm BERNARD LAUSON SEPT. 2000 /Medical 4c. County of Death 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner RICHIE HOSPICE Baltimore If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. HEM 20 F 0363 Yrs. 42 55 Director marylow Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTINGE 1 Yes 2 No 27 is marked other than "natural", or items 23s or 28s-f s traumstic avent, the Medical Everyons must be notified Directo Marylow 10f. Zip Code 10e. Street and Number 10g. Citizen of Whet Country? # 468 I W Franklin Street 21201 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 11. Meritel Stetus 1 Yes 2000 If Yes, Give Yeer or Dates: 1 Never Married 2 Merried Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐kNo Specify: Specify:-3 ☐ Widowed 4 ☑ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ALKER T ARVUN KEAL al Hygiena. Elementary/Secondery (0-12) College (1-4or 5+) Custopin Estate Company 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be filk. Department of Heelth end Mental Hy Important: If itam 27 ia marked oth any Injury or other traumatic avant Be Allester M. CHASE HARVEY L. LAWSON, Tr. 2 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 524 n. CHArles Street #811 Alleska M. Lawon I MUTINGE Baltimus md 21201 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Dete 1 Buriel 2 □ Cremation 3 □ Removel from Stete Baltinors Ausum Conetany 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility CHATMAN - Hamis 21. Signature of Funeral Service Licenses 5240 REISTERSTUN READ 23a. Pent Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Intervel Batween Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as e consequence of): physician and bunial-trar Physician/Medical the Due to (or as a consequence of) Pert It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 ☐ Yaa 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to Completed 24e. Was an autopsy performed? LAWSON completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) Hospice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred ernard 1 Matural 5 Pending investigation death. 1 Yes 2 No 2 Accident for Attand after death Director: 3 Sulcide 6 Could not be 28e. Plece of Injury - At home, farm, street, tactory, office building, etc. (Specify) 28t. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral E completely filled 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) and menner as steled. 2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and menner steled. 29a. Certifier Medical (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 008900 ted cause of deeth (Item 23a) (Type, Print) 30. Name and address of person who compl 28 N. Entano St. Balto. Md 21201

Registrar **DHMH 16 Rav 6/95** 

Kobert

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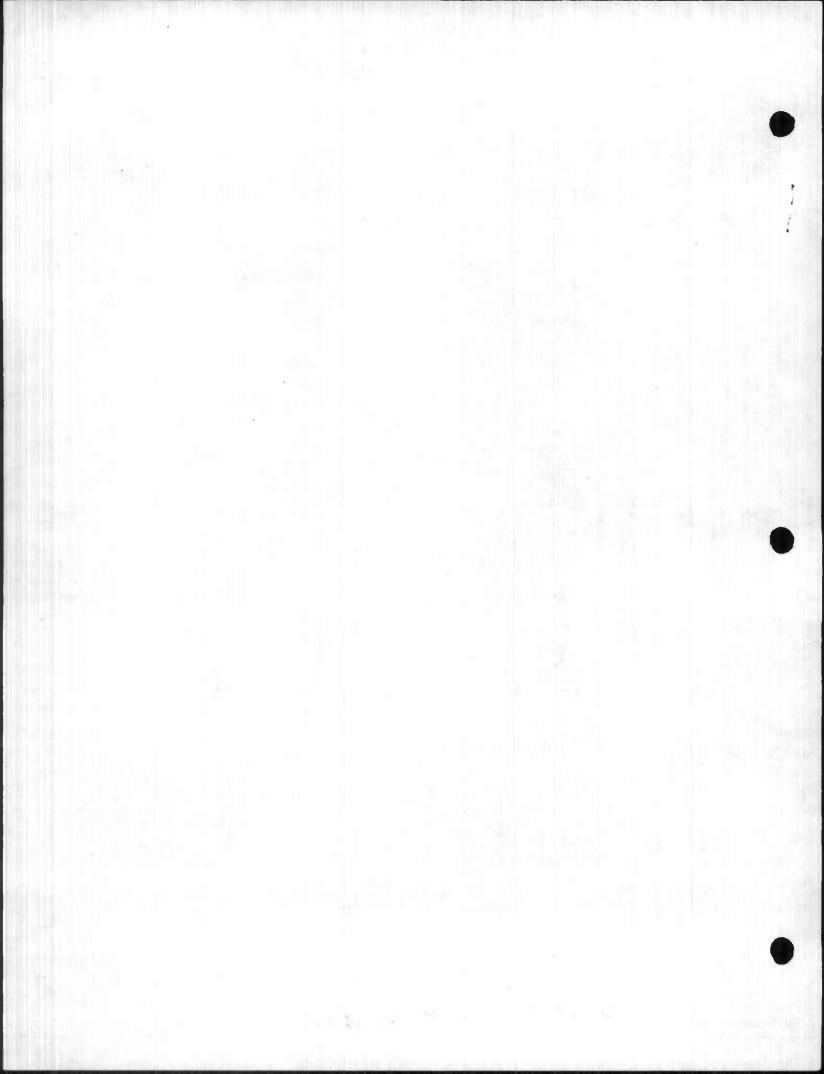
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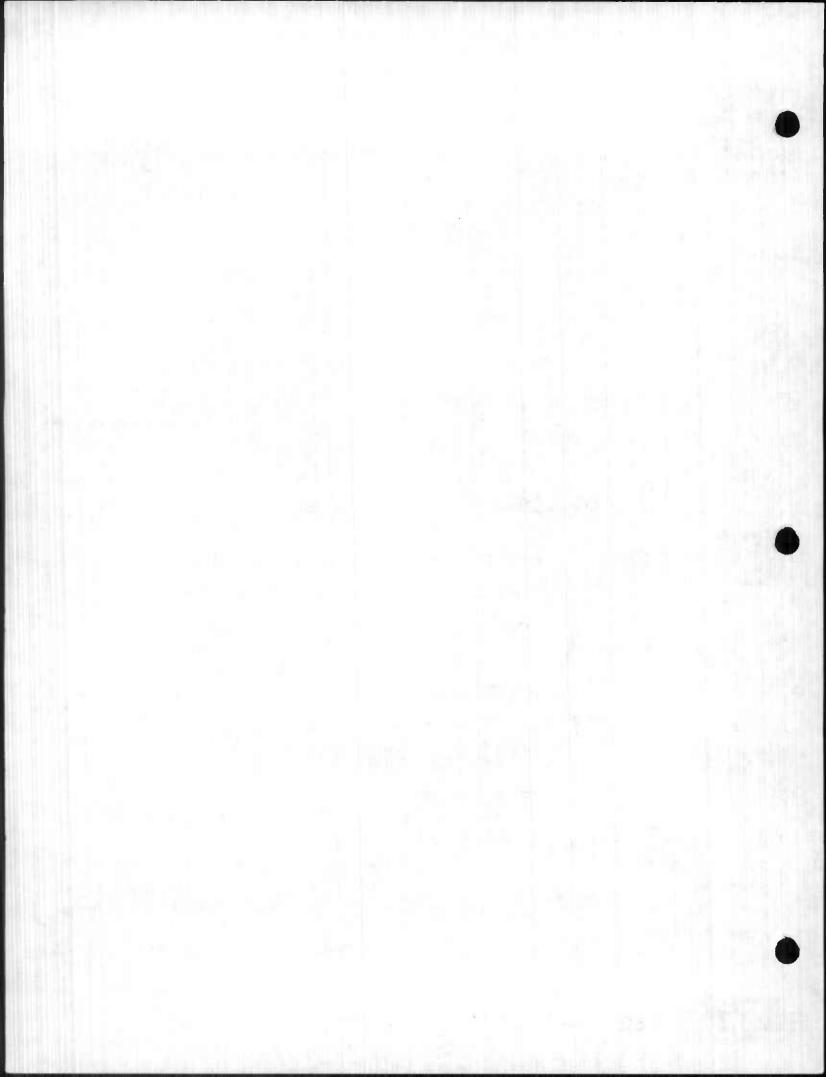
32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

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				Cei	rtificat	e of	Death			Reg. No.		200	O I
	Decedent's Neme (First, Middle, L	ast)		·					2. Date of Dea		Vear	3. Time of	Deeth
sician edical	Alice	Mo	sbv						SEPTEM	BEŘ 16	, <sup>Year</sup> 200	0 13:	:50 P
niner 40	Facility Name (If not institution, g	ive street and numb	per)				4b. City, To	wn, or Lo	cation of Deeth	4c. County	ot Death		
	CALVERT MEMORIA	L HOSPITA	L				Hunt	ingt	town	CALV	ERT		200
		Sex 7.	Age (In yrs. las		If Under Months		If Under Hours	24 Hrs. Min.	8. Dete of Birt (Month, Da)	h v, Year)	9. Birthp	olace (State o	or Foreign
	17-14-9746	IUM AUT	77	Yrs.					08-2	0-23		MD	
	uel Residence of Decedent  a. Stete 10b. County		10c. City.	Town or Lo	cation						1	0d. Inside Ci	ity Limits
		anda.										1 🗆 Yes	
10e	MD Calve	ELL	nun	ting	10f. Zig				1	10g. Citizen of	What Cour		XX
ă	4740 Paul Han	ce Road				639				USA		ш, у г	
2	Meritei Stetus	12. Wes Decede	ent Ever in U.S.	13.1				oin? (Spe	ecify Yes or No-		ce - Americ	an Indian.	-
5	1 Never Merried 2 Merried	Armed Force	es?		t Yes, spe	cify Cub	en, Mexicar	, Puerto	Rican, etc.)	Ble	ck, White,		
-	3 Widowed 4 Divorced	If Yes, Give Year or Dete			1 ☐ Yes	Mo No	Specify:			Specify	Bla	ck	
	15. Decedent's I	Education		16a. Deced	dent's Usu	el Occup	ation			16b. Kind ot B			
Completed	(Specify only highest g Elementery/Secondery (0-12)	rade completed) College (1-4	las E s \	(Give	kind of wo DO NOT u	rk done se retire	during mos	t of worki	ing				
5			ior 5+)	Bil	ling	CI	erk			Hilbe	rt O	ntica	1
17.	12th Grade Father's Neme (First, Middle, Las	2yrs.				-		er's Neme	e (First, Middle,	Maiden Sumer	ne)	porce	
	James W	alford					Ame	ila		Ceph	as		
190	e. Informent's Neme/Reletionship	(Type, Print)		19b. Meille	ng Address	s (Street			el Route Numbe	er, City or Town	, Stete, Zip	Code) 20	1630
1	Patricia K	yler		4740	Pau	1 H	ance	Roa	ad Hun	tingto	wn,	Maryl	and
208	a. Method of Disposition		20b. Ple	ce of Dispo	sition (Ne	me ol			Dete	20c. Location		The state of the s	
	1X Burial 2 □ Cremetion 3 4 □ Donation 5 □ Other (Spec		ete		-			nala	22-200	) Moo	d1	n, MD	,
21.	. Signature of Funerel Sayvice Lice		)				ss of Fecili						
	DI Margar	Tank!	1						altimo				.202
23	a. Pert1. Enter the diseese, or so shock, or heart lailure. List onl	mplications that cau	sed the deeth.	Do not ent	er the mod	de of dylr	ng, such es	cardiec o	O1 E.	rest,	AVE	Approximat Intervel Bet	le
2 res	equentially list conditions, inv. leading to immediate use. Enter Underlying use (Disease or Injury I) initiated events sulting in deeth) Lest	6. M31CO	Due to (or a Due to (or a	s a consec	quence ot):		2500	SIW	ic co	440100	Da		
Par	rt II. Other significant conditions	1	_	ing in the u	nderlying (	ceuse giv	ven in Pert	1.		obacco uss co		1.	
	1774 PIMEN ?	DUEDSE							10	Yes 2 No	3 Pro	Debty 4	Unknov
Completed by									24e. Wes perfo	en eutopsy med?	ev	ere autopsy aileble prior empletion of death?	to
E									160	res 2□ No	L	/	] No
	Wes case referred to medical						00 Pt	- A D A			- "	3163 20	1140
O B	axeminer?	Hospitel:		210		Ott	or.		h (Check only o		40		
27.	Menner of Death  Noterural 5 Pending Accident Investiget	28a. Dete ot (Month,	A	8b. Time of Injury		28c. Injui Woi	4UN		me 5 Resident			у)	
BLUICO	3 Suicide 6 Could not determine	he -	t Injury - At hom , etc. (Specify)	e, term, str	reet, factor	y, office			28f. Location (S City or Tox	Street end Num. vn, Stete)	ber or Run	Il Route Num	nber,
		hysician: To the beaminer: On the basi	is of examinetion										s)
	D. Signeture end title of certifier	d 0.	. 510100.	-	29	c. Licens	e number	-		29d. Dete signe	ed (Month.	Day, Year)	
	· Man	1 . ( W.	002	1110		OCMI							10
	mumme	vinedu	W	MW/		ou-ii	-			SEPTEM	DEK I	1, 200	10
30.	Name end address of person who	completed ceuse	of deeth (Item 2										
1	using simms	1-KOKEN		111	Penn	Stre	et, I	Balti	imore, 1	Maryland	1 212	01	
tate 31.	Dete filed (Month, Dey, Year)		istrer's Signetur	re L	A. Committee of the com		-			7			
strar	CED 1 8 201	nn / N	meren	Level .	AM	2. 40	/						



	)				Month	eath Day	3. Time of Death
al HART C. HOTT	-44444			4h City Tour			7.000
GI			116	A	7	Λ	
5. Social Security Number 6. Se	7. Age (In vrs.		If Under 1 Year	If Under 24			9. Birthplace (State or Foreign
212-36-2949	ом 20 г 62	Yrs.	Months Days	Hours	JAN. 8	, 1938	PENNSYLVANIA
Usuat Residence of Decedent	1.0.0		A!				404 1-14-05-11-5-
Ď .	NDEL BRO	OKLYN P.				40 000 41	
10e. Street and Number	T DD						
		IS 13 W		Hienanic Origi	n? (Specify Ves or N		
11. Merital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No				Puerto Rican, etc.)		ck, White, etc.
3 □ Widowed 4 🖔 Divorced	Yeer or Dates:	11.	□ Tes 241 NO	эреспу:		Specify	WHITE
15. Decedent's Edu	ucation de completed)	16a. Decede (Give ki	nt's Usual Occu	pation during most of	of working	16b. Kind of Bu	usiness/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		54	ed)		EI ECTRO	NITCC
		TECHNI	CIAN	18 Mother	s Nama /First Middle		
TAMES N MOTT							
	vne Print)	19h Mailing	Address /Stree				State, Zip Code)
J. MICHAEL MOTT /							
20e. Method of Disposition	20b. F	Place of Disposi	tion (Name of				
1 Burlal 2 Cremetion 3 F 4 Donation 5 Other (Specify,	demoval from State				2000		ILLE, MARYLAND
21. Signature of Fungral Service Licens	l				1		
1 At	il						
23a. Part1. Enter the disease, or comp	lications that coused the deat						·
shock, or heart tailure. List only o	ne cause on each line.						Onset and Deeth
							Oriodi and Dodin
Immediate Ceuse (Finet disease or condition	PNEU	(mon)	18				mangh
disease or condition resulting in death)	a. PNEU	and the second second			0.		1 month
disease or condition resulting in death)	· PNEU Chronic 1	and the second second		Zum	z dise	age_	1 month
disease or condition resulting in death)	b. Chilomic 1	and the second second		Zum	g dise	age	1 month  Syrs
disease or condition resulting in death)  Sequentielly list conditions, if smy, teading to Immediate cause. Enter Underlying Cause (Disease or Injury	b. Chronic Due to (c.	and the second second		Tum	g dise	age_	1 month 5 yrs 18 month
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disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Part II. Other significant conditions condit	Due to (c. Due to (c.	or as a consequence of the conse	ence of):  ence of):  ence of):  derlying cause g  28c. tnj  M  10  et, factory, office  coccurred at the the stringetion, in my  29c. Licer	26. Place of ther: 4 Nurse ork? Yas 2 Nurse ork? ime, date and opinion, death	23b. Dic 1 = 24a. Wa period Death (Check only sing Home 5 = Res 28d. Describe 28f. Location City or To	d tobacco use co Yes 2 No s an autopsy formed?  I Yes 2 No cone) sidence 6 Oth a how injury occur (Street and Numbown, State) a cause(s) and man, date and piace, 29d. Date signe	System 18 works  18 works  18 works  18 works  18 works  18 works  19 works  10 works  24b. Were autopsy tindings available prior to completion of ceuse of death?  1 yes 2 No  ner (Specify)  red  ber or Rural Route Number,  anner as stated.  and due to the ceuse(s)  and (Month, Dey, Year)

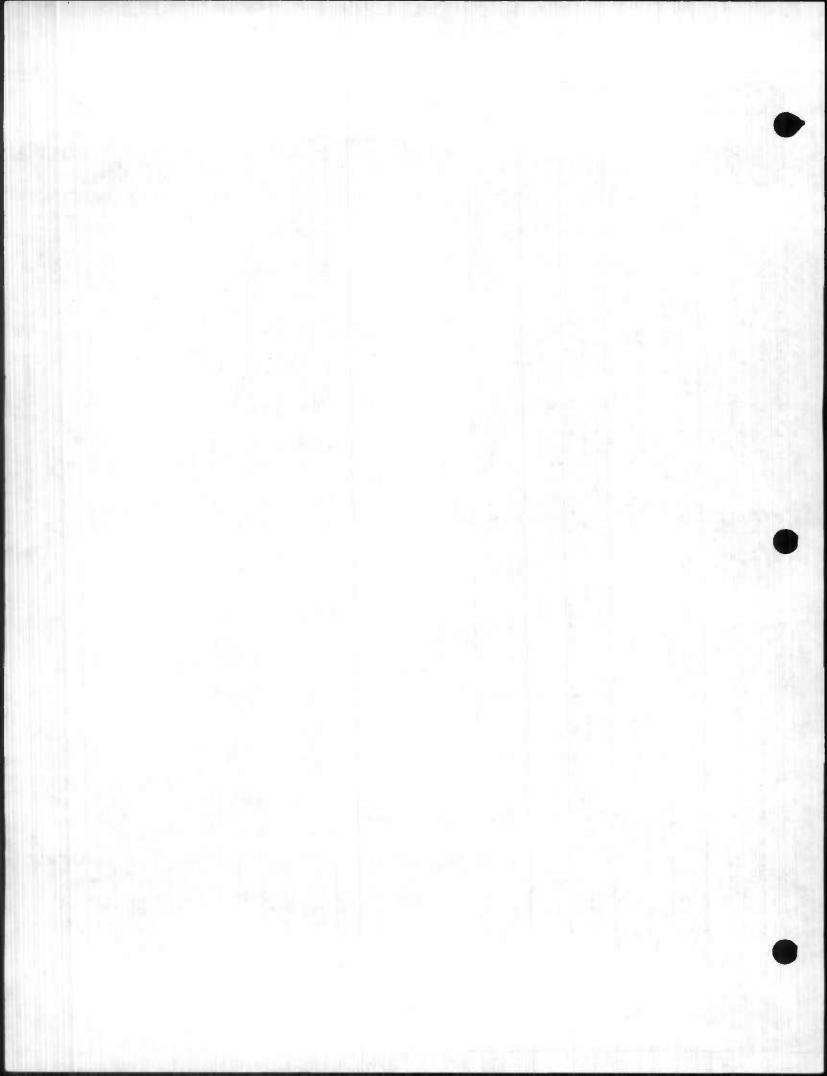
State Registrar

DHMH 16 Rev 6/95

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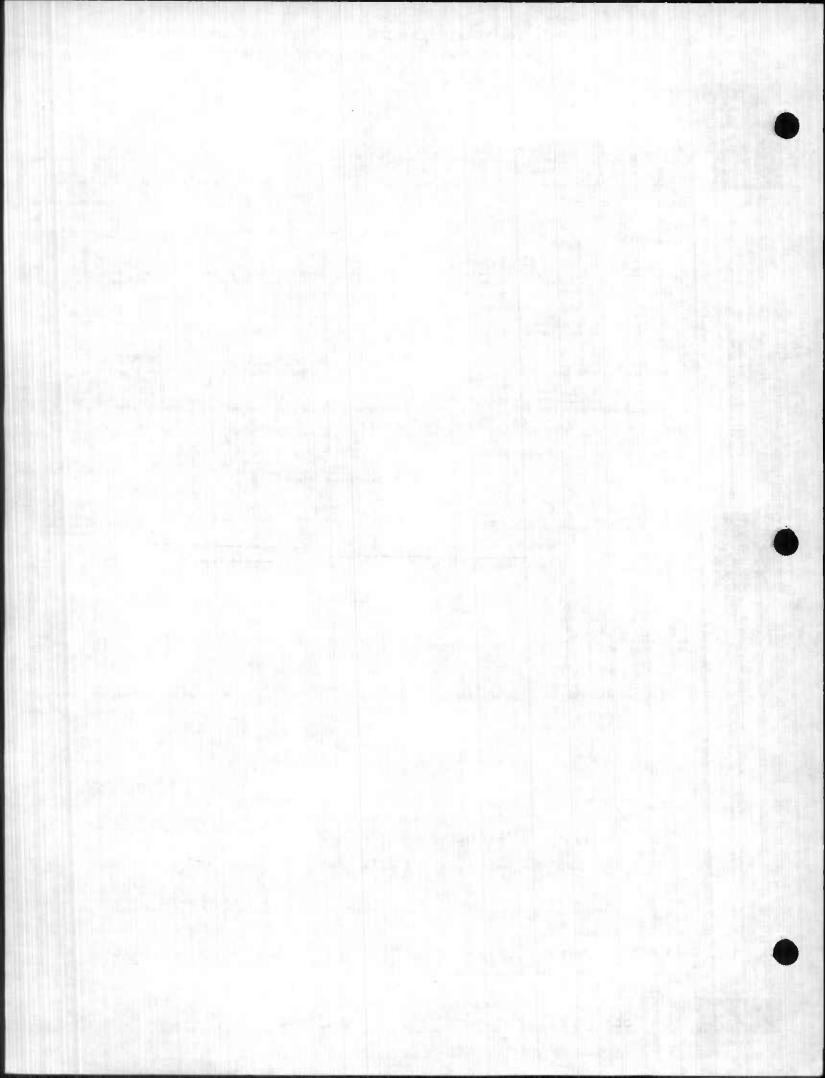
State of Maryland / Department of Health and Mental Hygiene 11 29353

	Decedent's Name (First, Middle, La.	st)	Oei (IIICa	te of Death	2. Date of De	Reg. No.	3. Ti	me of Deat
sician		MORENO			Month	Day NBCR 14	Year	100
ledical aminer	4a Facility Name (If not institution, giv				Location of Death	4c. County		WRE
neral ector	5. Social Security Number  2.13-26-42.88  Usual Residence of Decedent	ex 7. Age (In yrs.	9 Yrs. If Und	er 1 Yeer   If Under 24 Hr s Days Hours Mir		th by, Year) 7,1931	9. Birthplace (S PENNS)	
18	10a. State 10b. County	10c. Cit	y, Town or Location				10d. Ins	ide City Lin
notified at	MARILAND N	/A	K.	BALTIMO	RE CI	TI		Yes 2
al Dire	10e. Street and Number	WENER A	101.2	(ip Code	39	10g Citizen of V	Vhat Country?	
miner must be noticed Funeral Director	11. Merital Stetus 1 Never Merried 2 Merried	12. Wes Decedent Ever in U. Armed Forces? 1  Yes 2 No If Yes, Give		edent of Hispanic Origin? (secify Cuban, Mexican, Pue	Specify Yes or Norto Rican, etc.)	14. Race Blee	e - American Indi	en,
od by	3 Widowed 4 □ Divorced	Yeer or Detes:	16a. Decedent's Us	ual Occupation			ISINess/Industry	CK
rt, tre redice.	(Specify only highest gra Elementary/Secondary (0-12)  12 + HGRADE	completed) College (1-4or 5+)	(Give kind of v	vork done during most of w use retired)  NG A1	0	Augs	URY LUT	HERF
Be e	17. Father's Name (First, Middle, Last,		10 11 1 = 1	18. Mother's No	eme (First, Middle	, Meiden Sumem	ń O o d d	-
To	19a. Informant's Name/Relationship (	Type Print)	19b. Malling Address	ss (Street end Number or I	HEL Bural Route Numb	er. City or Town	State, Zin Code)	5
and injury or other treumatic event, the Manages.  To Be Comp	20a. Method of Disposition  18 Burial 2 Cremetion 3 C 4 Donation 5 Other (Specific	Removel from State	1722 Place of Disposition (A emetery, cremetory of DODLAWA	CEMETERY	Date 9-19-00	BALTI	MORE, MC City or Town, Sta MORE, H	IARYL
eny ic	23a. Part1. Enter the disease, or com shock, or heart failure. List only	Nuch	J94	ON. FULTE	BROWN NAVE.	BALTI	HORE, MI	2 Ho 2, 2/2 eximate
the burial-transit	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, [Disease or injury that initiated events resulting in death) Last	b. Due to (c	r as a consequence of res e consequence of	(f): (f):	ARCTI			
100		d						
ctor, page 2 should be detached for use Be Completed by Physician/A	Part II. Other significant conditions of	CARPIOM				tobacco uss co Yss 2□ No		1
2 should be pleted b	CONGESTIVE	E HEAR	r FAI	WRE '		sen autopsy ormed?	24b. Were aut available complets of death?	prior to
director, page 2					10	Yes 2 No	1 ☐ Yes	2)XNO
Be Be	25. Was case referred to medicat examiner?	Managhat. N			eath (Check only	one)		
	1 Yes 22No		ER/Outpatient 3		Home 5 Res	how injury occur		
fune	27. Menner of Death  12 Accident  3 Suicide  4 Homicide  2 Menner of Death  5 Pending investigation 6 Could not b determined	9 CO. Stern of taken Ask	28b. Time of Injury M ome, farm, street, fact	28c. Injury at Work? 1 Yes 2 No	28f. Location	(Street and Numb wn, State)		e Number
completely filled in by the Medical Certifical	29a. Certifier Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death occurre tion and/or investigati	ed at the time, date and place, in my opinion, deeth oc	ca, and due to the curred at the time	ceuse(s) and mi date and placa,	anner as stated. and due to the co	luse(s)
Me	29b. Signature and title of certifier  M.	<b>&gt;</b> .	2	9c. License number P 12561		29d. Date signe SEPTEM	GER 14	
U								



		A3.6T	MID#024 DET 150 (327 0	State of Marylan		ment of Hicate of				0 29354
	-		ND#23A PER MD. G787 9- Decedent's Nama (First, Middle, Last)	-22-2000 JAB	Cortin	cate or	Doutin	2. Data of De		3. Time of Death
A	Physician /Medical		ALFORD		MAR-	TIN	SR.	Septem	UR 10, 26	100 483 AM
A II	Examiner	40	Mary Land Gen Mary Land Gen	treet and number)	ital		4b. City, Town, or L Baltimor	ocation of Death	4c. County of	N/A
	Funeral Director	à	Social Security Number  6. Sax  37-50-0155	7. Aga (In yrs	. ravi birirouy	Under 1 Yaar onths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da APRIL		9. Birthplace (State or Foreign Country) NORTH CAROLINA
yland	# W	-	da. State 10b. County	10c. C	Ity, Town or Location	on				10d. Inside City Limits
h the Mg	be notified	10	1ARYLAND N	A		9-2-77/ 01. Zip Code	MORE	CIT	10g. Citizen of W	1 ✓ Yes 2 □ No hat Country?
9				E AVENU			2121	7	u	5A.
120 rs after de	of, or Herre 23s Examiner must		1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Evar in I Armed Forcas? 1  Yes 2 No If Yas, Giva Yaar or Dates:	It Ye	Decedent of I s, specify Cub Yes 2 No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, atc.)		- American Indian, c, White, atc.
5-0020			15. Decedent's Educ	eation	16a. Decedent	s Usual Occup	pation	l-i	16b. Kind of Bus	siness/Industry
2121	ygiene, se than 'natur t, the Medical		(Specify only highast grada Elementary/Secondary (0-12)	College (1-4or 5+)	n	-	during most of world)		1	
d 2			V. Fathar's Name (First, Middla, Last)		100DY	OHOP	WORKE 18. Mother's Nam	Re (First, Middle	Maiden Sumama	WLE REPAIR SHOP
/lan	Mental H rhad off fic ever fic ever		COLUMBIA	1	1ARTI	U	UNK			
Man /	la ma	1 /	9a. Intermant's Name/Relationship (Typ	11			and Number or Ru			
e,	Healt Sheri	-	TENRIETTA MART		Place of Dispositio	M VR7	LE AVE	Date 15	ALTIMORE 20c. Location - (	Mb. 2/2/7 Dity or Town, State
MO Pager	ne if it		1 Burlal 2 □ Cramation 3 □ Rd 4 □ Donation 5 □ Other (Specify)	emoval from State	cemetery, cremato	ry or other pla	ca)			DONE, MARYLAND
Balti	Departri Importa any inju	2	Signature of Funeral Service Ligense		22. Na	me and Addre	ess of Facility	BROW	NJR.F	UNERAL HOME MORE, MD. 21217
		2	3a. Part1. Enter tha disease, or complications, or haart tailure. List only on	cations that ceused the dea e causa on each lina.	th. Do not enter th	e moda of dyi	ng, such as cardiac	or raspiratory a	riast,	Approximate Interval Batween
/ I	ysician Medical caminer	di	nmediate Cause (Final seasa or condition suiting in death) a	Con Service	A INFARCTION OF AS A CONSEQUEN	TRACS!	Cundele	Mined	Irmiled.	Onset and Death
8	sit sit		b							
8760, at the be assecut	hysician and the burial-transit dical Examiner	SHOC	equentially list conditions, any, leading to immediate euse. Enter Underlying ause (Disaasa or injury		or as a consequen					
ox 6	d by the attending physietached for use as the	re	at initiated events sultting in death) Last	Due to (	or as a consequent	ce ot):				
. 8	the atte	Pt	nt II. Other algnificant conditions con	tributing to death but not re	sulting in the under	tying ceuse gi	ven in Part I.	23b. Dld	tobacco uae con	tribute to the cause of gleath?
P.O.	ed by the detached							10	Yea 2□ No	3□ Probably 4□ Unknown
Records,	should be							24a. Was	an autopsy prmed?	24b. Were autopsy tindings available prior to completion of cause of death?
plan	page 2							100	Yas 2□No	1 Das 2 No
/ital	director, page		5. Was case reterred to medicei axaminer?				26. Placa of Dea	th (Check only	ona)	
of Vita	SE P		1 ☐ Yes 2 ☐ No		1	BLI DOA			danca 6 Othe	
On	ector: Alter thi by the funeral	21	/. Manner of Death  1 Natural 5 ☐ Panding 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo M	rk? ]Yes 2 □ No	260. Describe	now injury occurr	80
Division of Vital	Directors Jin by the		3 Suicide 6 Could not be datarmined	28e. Place of Injury - At building, etc. (Spec	home, tarm, street, ify)	tactory, office			Street and Number	er or Rural Route Number,
- Hospital	within 24 hours after death.  To the Funeral Director: After t completely filled in by the funera  Medical Certification:	25		Ician: To the best of my kn er: On the basis of examin and mannar stated.						
Tothe	To the comp		b. Signature and title of certifier			29c. Licen	se number		01	(Month, Day, Year)
000	2		1 J Gong	mD		84	1312		91151	00
A.			Name and address of person who do	m.D.40	mar	y land	- Gene	Ral	Hospita	ul.
	State Registrar		SEP 1.8 200	32. Registrar's Sign	400	Span	Z,			

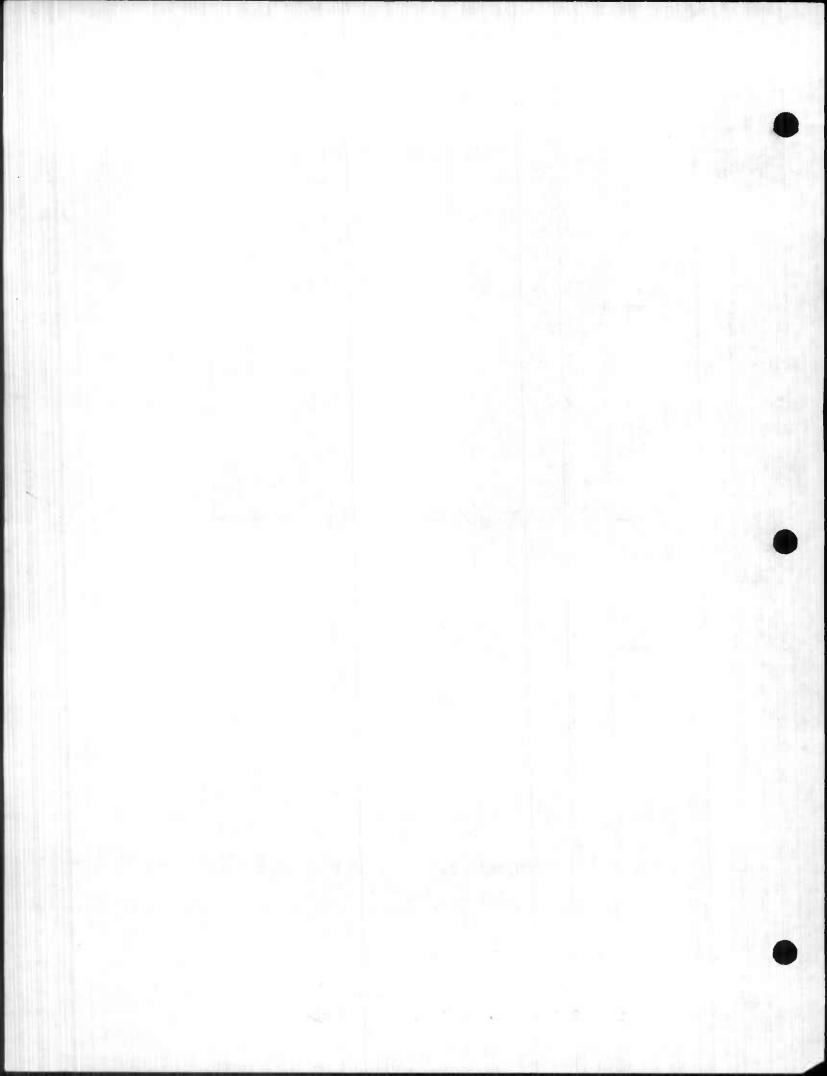
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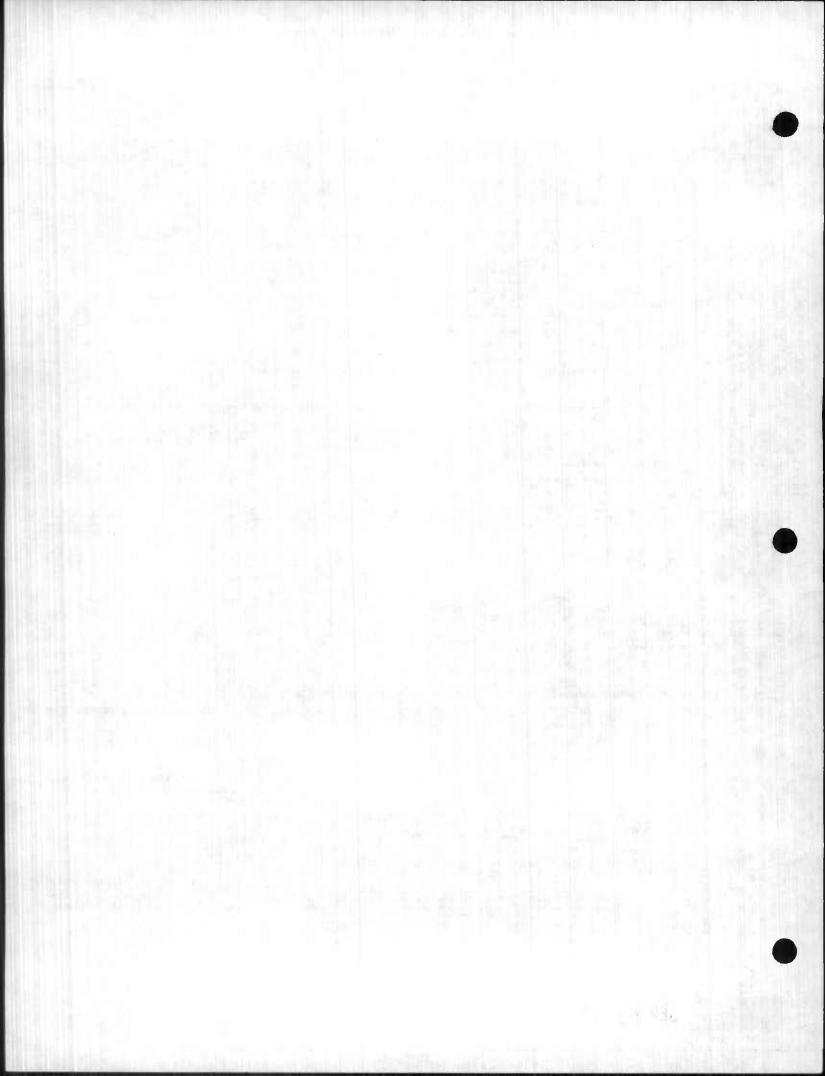
/ Department of Health and Ment	al Hygiene		20
Certificate of Death	Don No.	00	£ .

	Moten     Decedent's Name (First, Midd.)	la Lacti			Ce	rtitica	ite of	Death	2. Date of D	Reg. No.		355 ime of Death
cian	THEOD		OTEN						Month SEPTEM	Dey	Year	18 PM
cal ner	4a Facility Name (If not institution BON SECOURS 1	15-71-70						4b. City, Town, or L BALTIMORE			of Deeth	
	5. Social Security Number	6. Sex,	7. Ag	e (In yrs.	last birthday) Yrs.	Month	er 1 Year s Days	If Under 24 Hrs. Hours Min.	8. Dete of Bi (Month, D	irth ay, Year) 22.1951	9. Birthplace (S Country) South	
	Usuat Residence of Decedent								02111.2			
Director	10a. State 10b. County			10c. Cit	y, Town or L	ocation						ide City Limits  LYes 2 No
	MD N/	Α		P	BALTIN					and with Policy		X 20110
	10e. Street and Number					10f. 2	Zip Code			10g. Citizen of \	What Country?	
	2401 GARRI  11. Merital Status  1 Never Married 2 Mar  3 Widowed 4 Opivorced	ried 1	Mas Decedent Armed Forces? 1 Yes 2 0 1 Yes, Give Yeer or Dates:	Ever in U		If Yes, sp	212 cedent of h cecify Cub	116 Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		S OF A  Se - American Indi ck, White, etc.  BLA	
	15. Deceder (Specify only highe	st grade con	mpleted)		16a. Dece (Give	kind of v	sual Occup vork done use retire	during most of work	king	16b. Kind of Bi	usiness/Industry	
	Elementery/Secondary (0-12) 1 2 TH		College (1-4or :	5+)			ASHE			RESTA	IIRANT	
1	17. Father's Name (First, Middle,		TACAMIN			) I W	AUDI	18. Mother's Nam	ne (First, Middle			1017
	BEN.IAMIN	MOTEN	I					MILDRE	D NEI	SON		
	19e. Informant's Name/Relations				19b. Meil	ing Addre	ess (Street	and Number or Ru			State, Zip Code)	
	MILDRED MOTE  20a. Method of Disposition  1A Burial 2 Cremation  4 Donetion 5 Other (5	3 🗆 Remo			emetery, cre	matory o	r otner pia	JRY STRE		ALTIMOR 20c. Location - LAUREL		
	21. Signeture of Fundral Service 23a. Part1. Enter-the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	r complication only one ca	Lev	RRHYTH	h. Do not en	LEWI 4517 Iter the m	ST. PAF ode of dyi	ess of Facility GWYNN RK_HEIGH ng, such es cardiac	TS AVI	ENUE B	ALTO Appro	5-6393 MD. eximate al Between t end Death
		. I	HYPERTENS					EASE			i	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	c			or as a conse						8	
	Part II. Other eignificant conditi	ona contribu	iting to death b	ut not res	ulting in the	ınderivine	n cause ni	ven in Part I	23b. Die	d tobacco una co	entribute to the c	ause of death
	FATTY LIVER: ACUI									Yee 2□ No		
									24e. Wa per	s en eutopsy formed?	24b. Were eur available completi of death	prior to on of cause
									1/8	Îyes 2□No	108 Yes	2□ No
	25. Was case referred to medica examiner?	ıt						26. Place of Dea	th (Check only	one)		
	X□ Yes 2□ No	Hospi	1 L Inpatio		ER/Outpatie	ent 🐰	JOA			sidenca 6 Ott		
	Z D ACCIDENT	igation	8a. Date of Inju (Month, Da	iry Year)	28b. Time of Injury	of M	28c. Inju Wo 1	iry at ork? ] Yes 2 □ No	28d. Describe	how injury occur	rred	
	3 ☐ Suicide 6 ☐ Coutd 4 ☐ Homicide determ		8e. Placa of fn building, et	jury - At h	ome, ferm, si	treet, fect	ory, office		28f. Location City or T	(Street end Num own, State)	ber or Rural Rout	e Number,
	29e, Certifier 1□ Certifyle	ng Physician	On the basis o	1 exemina	wiedge, dea tion end/or in	th occurrenvestigati	on, in my	ime, dete end pleca opinion, death occu	, and due to the time	e cause(s) and m e, date and piece,	enner es stated. and due to the c	ause(s)
	(Check only 2 Medical one)		and manner st	orou.								



State of Maryland / Department of Health and Mental Hygiene 0 29356

			Cer	tificate of	Death		Reg. No.	2000
Physician	Decedent's Name (First, Middle, La     JOSEPH FR.		ILLER,	JR.		2. Date of D Month SEPTE	Day MBER 13	3. Time of Death Year 3. 2000 3:04PM
/Medical Examiner	4e Facility Name (If not institution, giv GREATER BALTI		L CENT		4b. City, Tov	vn, or Location of Dea	th 4c. County	
Funeral Director	5. Social Security Number 6. S		s. last birthday) 59 Yrs.	If Under 1 Year Months Days			irth Pay, Year)	9. Birthplace (State or Foreign Country) MARYLAND
2 .	Usual Residence of Decedent  10a. State 10b. County	100 (	City, Town or Loc	nation				10d. Inside City Limits
on 28s-f shorts to 28s-f shorts be notified at Director	MARYLAND ANNE	ARUNDEL		NTHICUM				1 ☐ Yes 210 No
	10e. Street and Number 110 SYCAMORE ROA	D		10f. Zip Code	21090		U.S.A	
Examiner must Examiner must by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	If Yes. Give	1959_ #	/as Decedent of H Yes, specify Cub	an, Mexican,	gin? (Specify Yes or N , Puerto Rican, etc.)		e - American Indian, ck, White, etc. WHITE
n, the Medical	15. Decedent's Ed (Specify only highest gra		(Give k	ent's Usuel Occup ind of work done O NOT use retire	during most	of working	16b. Kind of B	usinass/Industry
dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		EMPLOYED	0)		FLEA	MARKET
o Be C	17. Father's Name (First, Middle, Last) JOSEPH	MILLER	, SR.		18. Mother DOR I	r's Name (First, Middl	e, Maiden Suman OLSON	
T	19e. Intorment's Neme/Reletionship (	Type, Print)	19b. Mailin	Address (Street	end Number	r or Rural Route Num	ber, City or Town,	State, Zip Code)
d redio	MRS MARIE MILLE	20b.	Place of Dispos			LINTHICUM Date 9/18/20	20c. Location	O90 City or Town, State
(int) or	1 Burial 2 Cremation 3 4 Donation 5 Other (Specific	v) LO	UDON PAR	RK CEMET	ERY		BALTIMOR	
any in	21. Signature of Funeral Service Lie	11000						HOME, P.A., IE, MD. 21061
sician	23a. Part 1. Enfer the disease, of the shock for heart failure. List come	plications that caused the de one cause on each line.	eth. Do not ente	r the mode of dyi	ng, such as	cardiac or respiretory	errest,	Approximete Interval Between Onset and Death
ledical aminer	Immediate Cause (Finel disease or condition resulting in death)	a. Respir	atory	fai	line			12hours
Tie Li		Brain S	tem	Strok	e m	the ext.	Eusion	12hours
os the bural-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C	(or as a consequ	uence of):				
N Sing	resulting in death) Last	d						
e ettend od for us	Part II. Other significant conditions of	ontributing to death but not re	sulting in the un	deriving cause gir	ven in Part I.	23b. Die	tobacco una co	entribute to the cause of death?
igned by the ettend be detached for us by Physician						10	Yes 2□No	3 Probably 4 Unknown
should					Šų.	24a. Wa	s an autopsy formed?	24b. Were autopsy findings aveilable prior to completion of cause of death?
omp						10	Yes 2 No	1 Yes 2 No
director, page	25. Was case referred to medical examiner?				26. Plece	of Deeth (Check only	one)	
E =	1 Yes 2 No		ER/Outpatient	3LI DOA		rsing Home 5 Re	sidence 8 Oth	
Po Co	1 Neturat 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo M 1	ryat rk? ]Yes 2 □t		s now injury occul	
Director d in by th	3 Suicide 6 Could not b determined	28e. Place of Injury - At building, etc. (Spec	home, tarm, stre	et, factory, office		28t. Location City or T	(Street end Numi own, Stete)	ber or Rurel Route Number,
To the Funeral Director: After the completely filled in by the funeral Completely filled in by the funeral Medical Certification:	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my ki niner: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the ti estigation, in my	me, date end opinion, deat	d place, end due to the th occurred at the time	e cause(s) end m e, date end place,	anner es stated. and due to the cause(s)
Ne Me	29b. Signeture and title of certifier			29c. Licens	se number		29d. Dete signe	od (Month, Day, Year)
	1 matilde	H. So, A	Con	1	262		9/14	12000
	30. Name and address of person who MATILDA H	completed cause of death (the	em 23a) (Type, F	Print)	RIZG	STR	A TIMO	MG, MD. 21244.
State	31. Date tiled (Month, Day, Year)	32. Registrar's Sig	pature /	- dul	1-503	/ ( 10	710111-0	0, 0, 0, 0, 1
Dawleter	SEP 1 8 2000	hours !	y do	2. V.				



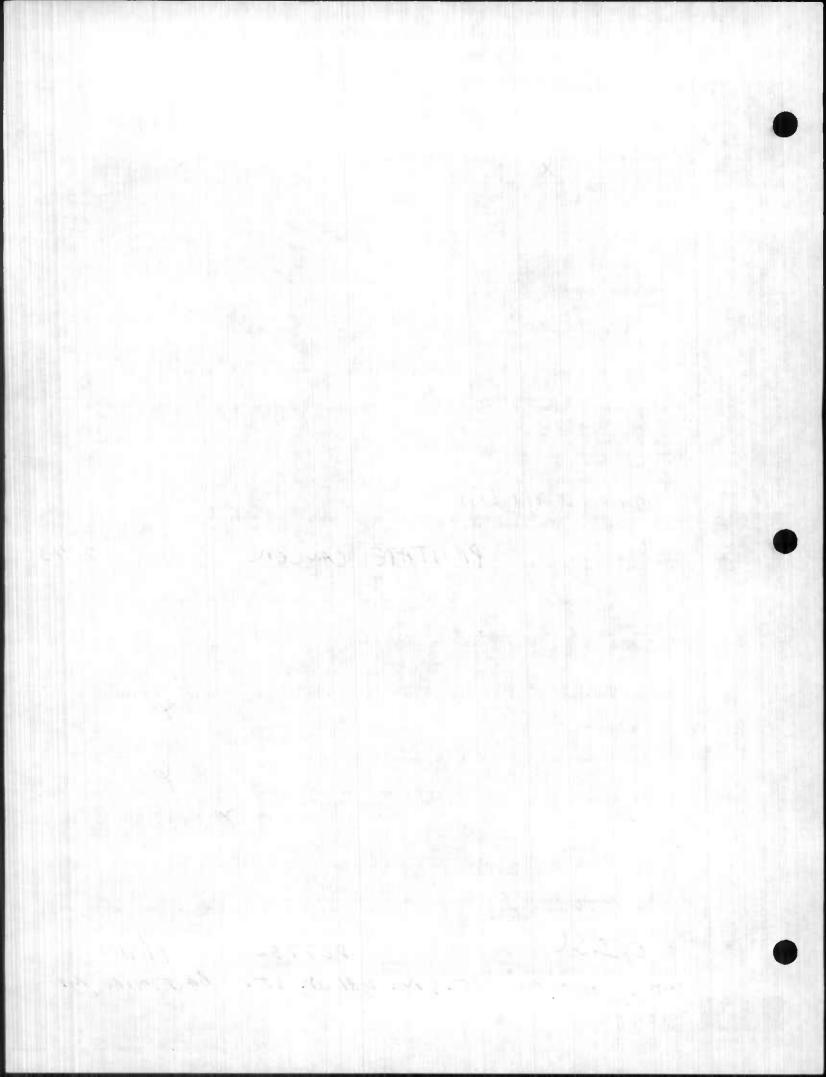
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 5:37PM 09-13-2000 CLAUZELL /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 5322 MIDWOOD AVENUE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) Funeral 1 MM 2□ F Months Days Hours Min Yrs. Director 63 08-07-1937 MD 216-34-6380 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or flams 23s or 28s-f show the Medical Examiner must be notified at 1 Nes 2 No MD BALTIMORE Director N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5322 MIDWOOD AVENUE 21212 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Merital Stetus filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 ▼No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent'a Education (Specify only highest grade completed) 16a. Decedent's Uaual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 100 Elementary/Secondary (0-12) College (1-4or 5+) CIRCUIT BD. TECHNICIAN LUCENT TECHNOLOGY 12 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Montal NELLIE MONDIE MACK MONDIE 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) . MYRA MONDIE/WIFE 5322 MIDWOOD AVENUE BALTO., MD. 21212 Department of Health Important: If Item 27.1 Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removel from State ARBUTUS 9/18/2000 BALTO., MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme and Address of Facility
JAMES A. MORTON & SONS F.H., INC 21. Signature of Funeral Service Licensee any h a. 1701 LAURENS ST. BALTO., MD. 23a. Per(y. Enter the disease, or complications the shock, or heart failure. List only one cause. hat caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) 2 4/5 /Medical PROSTATE Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760, aftending physician use as the Due to (or as a consequence of): P.O. be detached Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did lobacco use contribute to the cause of death? the 2000 3 Probably 4 Unknown been signed by 1 Yea Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? funeral director, page 2 should 24a. Was an autopsy performed? Be Completed this certificate has 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2000 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 □Other (Specify) Medical Certification: To 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of after death.
Director: After to d in by the funeral Matural 5 Pending 1 Yes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Cartifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier A27730 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) GOTG GN.CHARUS. ST. BATTIMORE MY COVIEW 40

DHMH 16 Ray 6/95

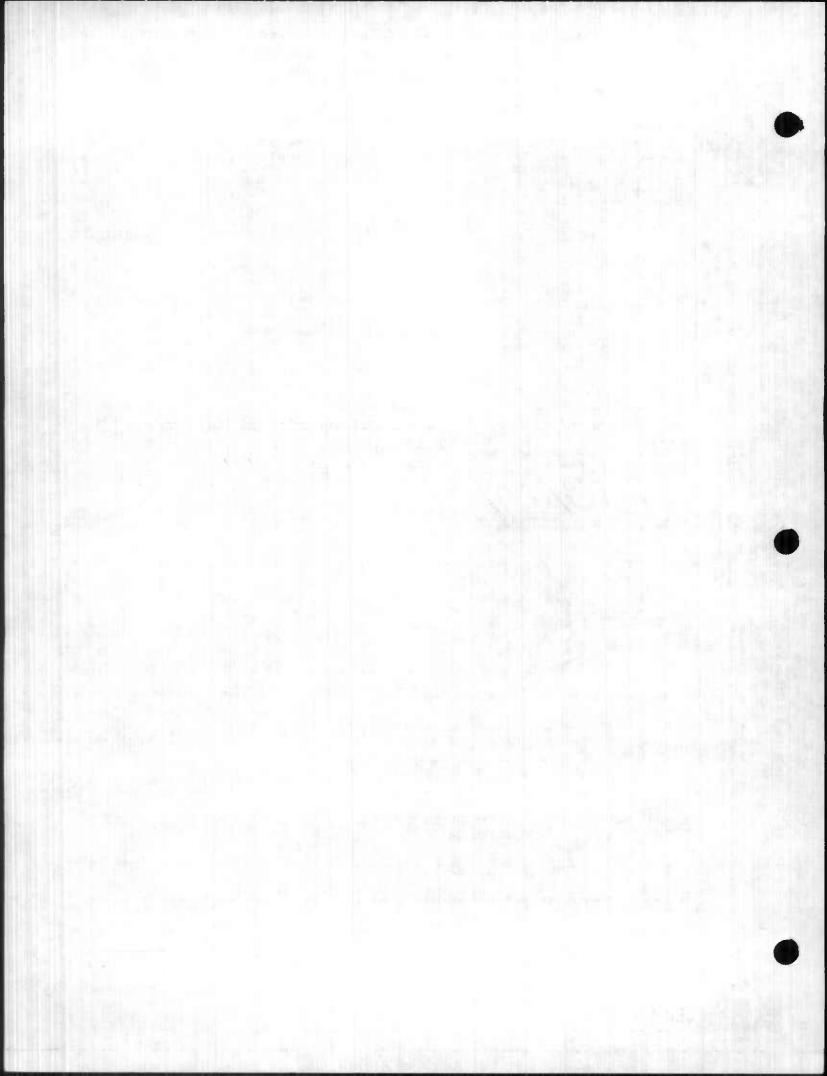
State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature



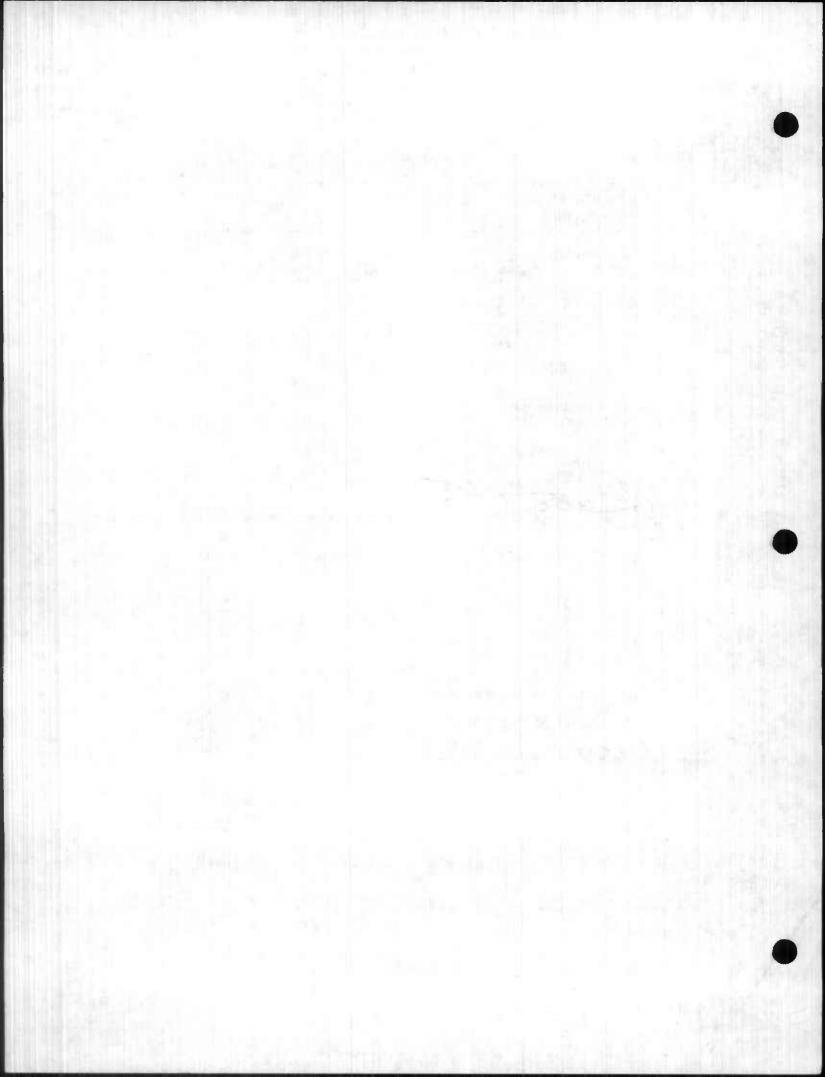
State of Maryland / Department of Health and Mental Hygiene 10 20358

Ы	a Lings		AMEND#29D F	PER MD. G78					icate of		montal riy	Reg. No.	0 2	9330
	<b>5</b> 1		1. Decedent'a Name	a (First, Middla, La	st)						2. Data of De Month		/aar	3. Tima of Death
	Physicia		Car	coline H.	Medina							15, 2000		6:00 AM
	/Medic Examin		4a Facility Nama (/	f not institution, giv	e street and num	nber)				4b. City, Town, or	1		Death	Frank Hold
	LAGIIIII	CI	136	21 Allis	ton Driv	ze.				Baldw	in	Ba	ltimo	re
	Funeral Director		5. Social Security N 219-34-46	umber 6. S			yrs. last birth	340	Under 1 Yaar ontha Days	If Under 24 Hrs	8. Data of Birt	h v. Year)		a (Stata or Foreign
ш			Usual Residence of				50				1100. 1	7, 1310	vary.	IIII
	death with the Maryland me 23a or 28a-f show r must be notified at	2	10a. Stata	10b. County		100	. City, Town						10d.	inside City Limits 1 ☐ Yes 2 ② No
	N of the M	ct	Md.		timore		В	aldw						A
	with th	Director	10e. Street end Nur	Alliston	Dwino			11	0f. Zip Coda 210	12		10g. Citizen of Wh		?
	a 23	era		ATTISCON	12. Was Dece	dont Ever	211 ai	12 18/00			Enneity Ves of No		- American	indian
21215-0020	n 72 hours after death with the Marylan "natural", or frems 23a or 28a-f show safer Earn for mist be notified at	by Funeral	11. Marital Status  1 Nevar Marri  3 Widowed	ed 2 Married 4 Divorced	Armed For 1  Yaa If Yas, Give Year or Da	ces? 2 ☑ No a	iii 0,5.		s, specify Cub	Hispanic Origin? (: an, Mexican, Pue Specify:	to Rican, atc.)	Black Specify:	White, atc	
0-0	72 ho	P	/0	15. Decedent'a E			18a. D	Decedant's	s Usual Occup	pation	retina	16b. Kind of Bus	inass/Indus	try
21		Completed	(Speci Elemantary/Seco	ndery (0-12)	Coilege (1-	-4or 5+)	()	lifa. DO N	VOT usa retire	during most of wo d)	n N II I I			
2	77 70 10	Ö				4	Но	mema	ker			Own H	ome	
	be filed tal Hygid d other avant, the	Bec	17. Fathar's Nama	(First, Middle, Last	)					18. Mother's Ne	ma (First, Middla,	Maiden Sumama	)	
<u>a</u>	0 2 0 a	To B	Richar	d F. Hil	liard					Stel	la Evans			
Maryland	2 should end Men la merke eumetic	-	19a. Informant's Na	me/Raiationship /	Type, Print)		19b. N	Mailing Ad	ddrass (Street	and Number or R	lural Routa Numbe	er, City or Town, S	tata, Zip Co	ode)
Ž	d 2 the		Mrs. Mary				136	521 A	llisto	n Drive	Baldwin.	Marylan	3 210	13
à	- 9 5 5	1	20a. Method of Disg		augirour	20	b. Place of D	Disposition	n (Name of		Date	20c. Location - C		
Baltimore,	eges ent of rt: If It y or c		1 Burial 2	☐ Cramation 3 ☐ 5 ☐ Other (Specil		State	cematery,	cramato	ny or other pla Mem. P					Maryland
Ball	permit, Pe Depertmen Important: any Injury ance.		21. Signature of Fu	neral Service Lice	Red	1			ma and Addre	. 1		on Funer Maryland		
			23a. Part1. Entar ti shock, or haa	na disaase / com	plications and a	used tha	daath. Do no	ot antar th	a moda of dyl	ng, such as cardia	c or raspiratory a	rrest,	A	oproximata tarval Batween
	Physician /Medical Examiner	lner	Immediata Causa ( disaasa or conditio raaulting in death)	Final n	a	Dua	to (or as a co	PHO					m	ONTHS
68760,	ficate be executed g physician and es the bunal-transit	edical Examiner	Sequentially list co- if any, leading to in cause. Enter Unda Cause (Disease or that initiated evants resulting in death) I		с.		to (or as a co							
Вох	E 00	Physician/Me	Part II Other almit	L	d.	ath hut and	h dan ulkina la h	No and de		van in Dont i	ook Did	tehanco una cont	     	e cause of death?
	that the ed by the detacher	/ Phys	Part ii, Other algnif	cant conditions t	onthouting to de	atti but noi	trasoning in t	ina unuan	iying causa gi	ven in rait i.	1 🗆	-	3 Probat	
Division of Vital Records,	e law requires that the death cert hes been signed by the attendin ge 2 should be detached for use	Completed by									24a. Was	an autopsy ormed?	availa	autopsy findings ibla prior to letion of cause ath?
I	The page	0									10	Yas 28 No	1 🗆 Y	as 20 No
12	icentificate rector, pag	Be	25. Wes casa rafar	red to medical						26. Placa of De	ath (Check only	ona)		
>	Physician: this certific ral director,	TOE	examinar?	No	Hospitai:	patiant	2 ER/Outp	patient 3	DOA ON	har:		dance 6 Otha	(Specify)	
0	Phy pr thi		27. Mannar of Deat	h	28a. Data d	of Injury	28b. Tir	ma ot	28c. inju		1	how injury occurre		
0	oding th.	to	1 Natural 2 Accident	5 Panding invastigatio		h, Day Yes	ir) Inj	ury		rk? ]Yas 2 □ No				
DIVISI	For Attanding after death.  Director: After in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicida	6 Could not be detarmined	e 28a. Placa	of Injury - ng, atc. (Sp	At homa, fam pecify)	m, straat,	factory, office		28f. Location ( City or To	Street and Numbe wn, Stata)	r or Rural R	louta Number,
	To the Hospital or Attanding Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	edicai C	29a. Certifier (Check only one)	1 Gertifying Pt 2 Medical Exam		sis of axar						causa(s) end man data and place, a		
	within To the comple	Me	29b. Signature and	title of certifier					29c. Licans	sa number		29d. Data signad	(Month, Da	y, Year)
				Azi					1	13721	2	21	1.	L 0 /1 = /0000
	8		1	Culas						13736	-	77	3/00	9/15/2000
JA	\$ 5+3		30. Name and addr.	assolol peraon who	completed cause	of death	(itam 23a) (T	ype, Print	A	d 32	Currier	vine	mer	1093
	Sta Registra		SEP 1 8 2	th, Day, Year)	Separa 32. Re	egistrar's 8	Signatura	aks						



State of Maryland / Department of Health and Mental Hygiene

				Ce	rtificate of	Death		Reg. No.	29359		
		1. Decedent's Name (First, Middle, La	st)					2. Date of Death 3. Tin			
	Physician	LILA	LEE	LEE NICOLAISEN			Month SEPTE	MBER 14,	Year 2000 2:00 PM		
	/Medical Examiner	4a Facility Name (If not institution, give street end number)			4b. City, To		n, or Location of De				
	Examiner	HAMMONDS LANE N	URSING HOME			BROOM	KLYN PARK	AN	NE ARUNDEL		
-	and 2 should be filed within 72 hours after death with the Maryland agin and a Montal Hygiene.  At 71 is marked other than "natural", or form 23a or 28a-f show and the framework of the Maryland and the Maryland	5. Social Security Number 6. S	in yrs. last birthday) If Under 1 Year If Under 24 Hrs.			Birth Dey, Year)	9. Birthplace (State or Foreign				
		216-28-4297 Usual Residence of Decedent	69 Yrs. Months Days Hours Min.				(Month, Dey, Year) Country) JUNE 28, 1931 MARYLAND				
		10a. State 10b. County 10c. City, Town or Location 10d. tnsida City Limits									
aryland 21215-0020		MARYLAND ANNE ARUNDEL  10e. Street and Number		GLEN	GLEN BURNIE			1 ☐ Yes 2)(2) No 10g. Citizen of What Country?			
		107 OLD FARM COURT			21060			U.S.	U.S.A.		
		11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 27 No tf Yes, Give Year or Dates:	r in U,S. 13.	Was Decedent of If Yes, specify Cu	ban, Mexican,	in? (Specify Yes or Puerto Rican, etc.)		a - American Indian, k, White, etc. WHITE		
		15. Decedent's E (Specify only highest gri	ducation	16a. Decedent's Usual Occupation		of working	16b. Kind of Business/Industry				
		Elementary/Secondary (0-12)			(Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			OWN HOME			
		17. Father's Nama (First, Middle, Last	)		100	18. Mother	's Name (First, Mide	dle, Meiden Sumem	е)		
		RICHARD ALLAN THORNE ESTHER CAP					PITOLA EADES				
		19a. Informant's Name/Relationship (	Type, Print)	19b. Mai	ling Address (Street	et end Number	or Rural Route Nu	mber, City or Town,	State, Zip Code)		
		DANIEL RAY NICO	LAISEN (SON	1) 192	2 PORTOBA	GO LAN	E, HANOVE	R, MARYLA	ND 21076		
altimore,	-216	20a. Method of Disposition		20b. Place of Disp	osition (Name of	lece)	Date	20c. Location -	City or Town, State		
Ë	0-=0	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		•			RK 9-18-00	GLEN BUR	NIE. MD.		
HE		4 Donation 5 Other (Specify) GLEN HAVEN MEMORIAL PARK 9-18-00 GLEN BURNIE, MD.  21 Signature France Service Licenses 0.000 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A.,									
Ö	Departi Departi Imports any inj ance	1 KVB	101001	3	SECOND	AVENUE	, S.W., G	LEN BURNI	E, MD. 21061		
		23a. Part. Erler the disease, or com- shock or legat follure. List only	plications that caused the	death. Do not e	nter the mode of dy	ying, such as c	ardiac or respirator	y arrest,	Approximate tntervat Between		
	Physician -	Onset and Death									
	/Medical   Examiner	Immediate Cause (Final disease or condition resulting in death)  a. DEMENTIA, ALZHEIMER Type 8/eacs  Due to (or as a consequenca of):									
	THE REAL PROPERTY.										
	P # P										
	be executed sician and burial-transit	Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying									
60,	cian burial	If any, leading to immediate cause. Enter Underlying Cause (Disease or Injury									
68760	ficate be physicia as the bur edical	that initiated events resulting in death) Last Due to (or as a consequence of):									
	ing p	d.									
Вох	es that the death certificate be executed igned by the ettending physician and be detached for use as the buriat-transit by Physician/Medical Examir										
0		Part II. Other stgniftcant conditions contributing to death but not resulting in the underlying cause given in Part t.					23b. D	23b. Did tobacco use contribute to the cause of death?			
0		HYPERTENSION OSTEOPOROSIS					1	1 Yes 21 10 3 Probably 4 Unknown			
Records,	signe d be d	24a. Was an autopsy 24b. Were autopsy findings									
O	been sign should be	OSTEOPOROSIS performed? available prior completion of comp							available prior to completion of cause		
Sec	The law ate has be page 2 s								of death?		
=								☐ Yes 2 10 Mo	1 ☐ Yes 2 ☐ No		
		25. Was case referred to medical axaminer?	11		26. Place of Death (Check only one)						
900	5 6 5	1 Yes 2 No	Hospital: 1   Inpatient	2 ER/Outpatio	ent 3LI DOA		-	lesidenca 8 Oth			
n c	eath. or: After th the funeral cation: "	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Dete of tnjury ding (Month, Dey Year) 28b. Time of tnjury 28c. tnjury at Work? 28d. Describe how injury occurred								
Sio	eath. or: A	2 Accident investigation 3 Suicide 6 Could not be	he l								
Division	tal or Attending P as after death.  In Director: After tied in by the funer; Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number of Development of Pour Pour Pour Pour Pour Pour Pour Pour						er or Hural Houle Number,		
0	Se de Co										
	in 24 hours he Funer pletely fil	29e. Certifier  (Check only and control of the basis of examinetion and/or investigation, in my opinion, death occurred at the time, determined the time, determined the time, determined the time, date end place, and due to the cause(s)									
	To the Hospital or Attanding Physician 24 hours alter death. To the Funerel Director: After the completely filled in by the funeral Medical Certification:	29h Signature and title (2 certifier	and manner states		29c Lica	nse number		29d. Date sinne	d (Month, Dev. Year)		
	7 × 7 8	29b. Signature and title O certifier 29d. Date signed (Month, Dey, Year)									
		1 mod - 1 0025/7 5277 15 00									
	2	30. Name and address of person who completed cause of death (frem 23a) (Type, Print)  [Click & F. & F. & N. & F. & M. D. Crain Toward & M.C.									
	Stote	31 Date filed (Month, Day, Year)	2 32 Registrar's	Signature /	1	Clul	7 100	0013	1 ( ) 1		
	State Registrar	3 Pite filed (Month, Pay, Year)	Densira /	Spa	ella :						

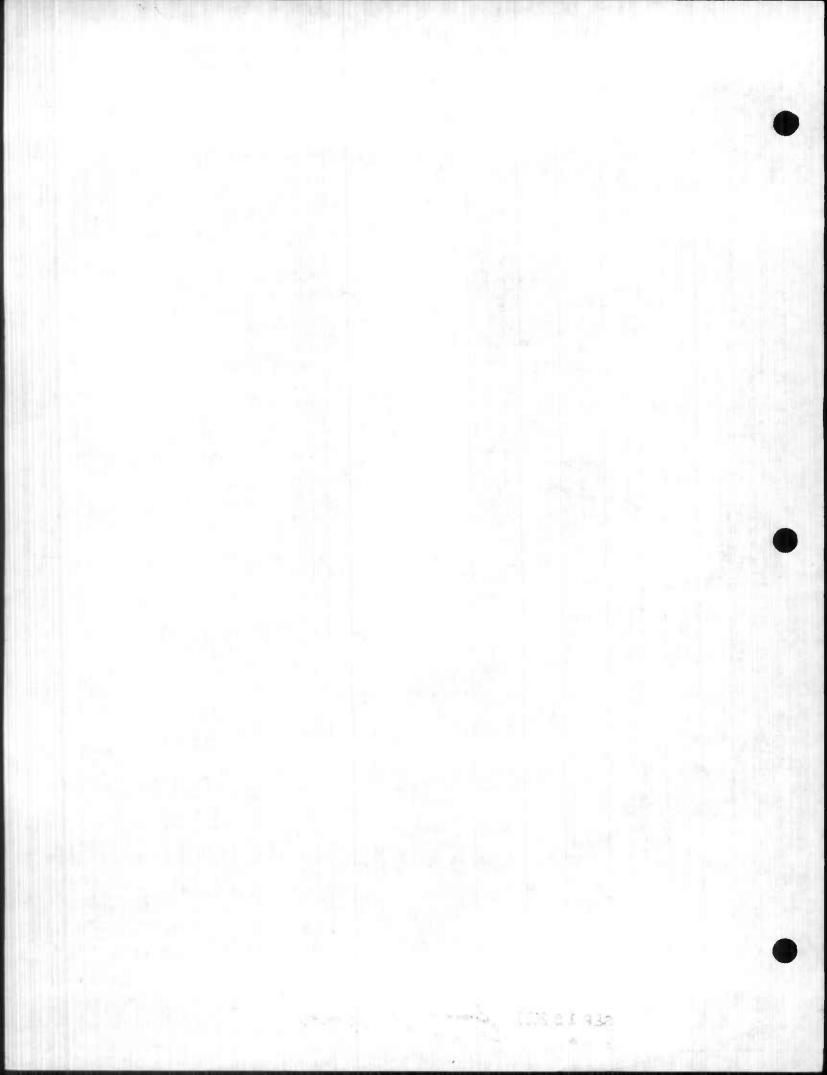


State of Maryland / Department of Health and Mental Hygiene

29360 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1622 September 13,2000 HENRY B. PULLEY SR. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) Examiner BALTIMORE
If Under 1 Year If Under 24 Hrs. 8, Date of UNION MEMORIAL 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10XM 20 F Months Days Hours Min. Yrs Director 01 - 05 - 23VA 218-14-7450 Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 No Yas 2 No Director MD N/A BALTIMORE the Medical Examiner must be notifie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8 238 Funeral 21215 U.S.A. 2500 W. BELVEDERE AVE 14. Race - American Indian, Black, White, etc. Herne 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 8 Maryland 21215-0020 1 □ Yes 2 No Specify: Specify: by 3 ₩ Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene other than Elementery/Secondary (0-12) College (1-4or 5+) CREDIT CARD SALES 12 SUPERVISOR 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumame) should be ind Mental th and Meni 7 is marked traumatic a GRACE NEWLAND HENRY PULLEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 of Health Item 27 3905 FERNDALE AVE, BALTO. MD BARBARA JONES, DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of Important: If its any injury or o b 1 ☐ Muriat 2 ☐ Cremation 3 ☐ Removal from State 9-19-00 RANDALLSTOWN, KING MEMORIAL PARK 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funding Service License 22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE BALTO. MD 21207 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or conditications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner Rena Stage The law requires that the deeth certificate be axecuted Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting In death) Last Due to (or as a consequence of) Box 68760. Due to (or as a consequence of) 98 980 P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? detached 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, by 2 should be 24b. Were eutopsy findings svaileble prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 1 Yes 25 No 1 Yes 2 □ No or Attending Physician: director. Be 25. Was cese reterred to medicel 26. Place of Deeth (Check only one) 1 Yes 20 No Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Netural 2 Accident 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No the 3 Suicide 6 Could not be determined 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, term, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Hospita Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, dete and place, and due to the cause(s) 29a. Certitier (Check only one) and manner steted. To the 29b. Signature and title of prtifier 29d. Date signed (Month, Day, Year) 29c. License number September 13, 2000 AT2438946-A10 NO 30. Name and address of person who completed ceuse of death (Illen 23a) (Type, Print) WOLF Y Parkway BALTIMORE, MD 21218 UMH 201 East 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 1 2 2000 Registrar **DHMH 16 Rev 6/95** \*\*= \*

**ORIGINAL** 



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** PALUSKIEVICZ 5:37 PM SEPTEMBER 14 2000 JERRY /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE JOHNS. BAYVIEW MEDICAL CENTER HOPKINS 7. Age (In yrs. lest birthdey) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Numbe 8. Date of Birth (Month, Day, Year) **Funeral** Days 10 M 20 F Hours Months 234-62-6159 59 Director West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 25a-f show Dundalk 1 ☐ Yes 2 No Director Baltimore A Hygiene, of terms 23e or 28e-1 other then "neture", or terms 23e or 28e-1 other went, the Medical Exemples must be notified Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 8173 Mid Haven Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2€ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☑ Merried 1 Yes 200 Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Pharmaceutical Elementary/Secondary (0-12) College (1-4or 5+) Medical Pharmacy Technician 12 Years Maryland 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) ad bluods Mental marks Charles Henry Ballengee Georgia Lee Carraway 19e. Informent's Neme/Relationship (Type, Print) (Husband) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) important of Health a important if Nem 27 is a any Injury or other 005s. 8173 Mid Haven Road Dundalk, Maryland 21222 Mr. Robert P. Paluskievicz Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State \*Buriat 2 Cremation 3 Removat from State Hill Mem. Gdns. 9/18/2000 Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility
Duda-Ruck Funeral Home of Dunalk, Inc. Dundalk, Maryland 7922 Wise Ave. Part. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on eachine. Approximate Intervat Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical SEPTIC SHOCK Examiner Due to (or as a consequence of) Physician/Medical Examiner PULMONARY FIBROSIS The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequence of): Box 68760 thet initieted events resulting in death) Last Due to (or es a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Dld tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown FAILURE RESPIRATORY Division of Vital Records. p 24b. Were autopsy findings aveitable prior to completion of cause of death? Be Completed 24a. Wes an autopsy ANOXIA performed? CEREBRAL 1 ☐ Yes 2 No 2 X No this certificate 1 Yes i or Attending Physician: after death, funeral director, 25. Was case referred to medicat examiner? 26. Piace of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Medical Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? After Injun 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation eral Director: A 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital c within 24 hours at To the Funeral D completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

DHMH 16 Rev 6/95

SEP 1 8 2000 31. Date fil Registrar

4940

29b. Signature and title of

30. Name and address of person

EASTERN

AVENUE 3. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

M. AHMED

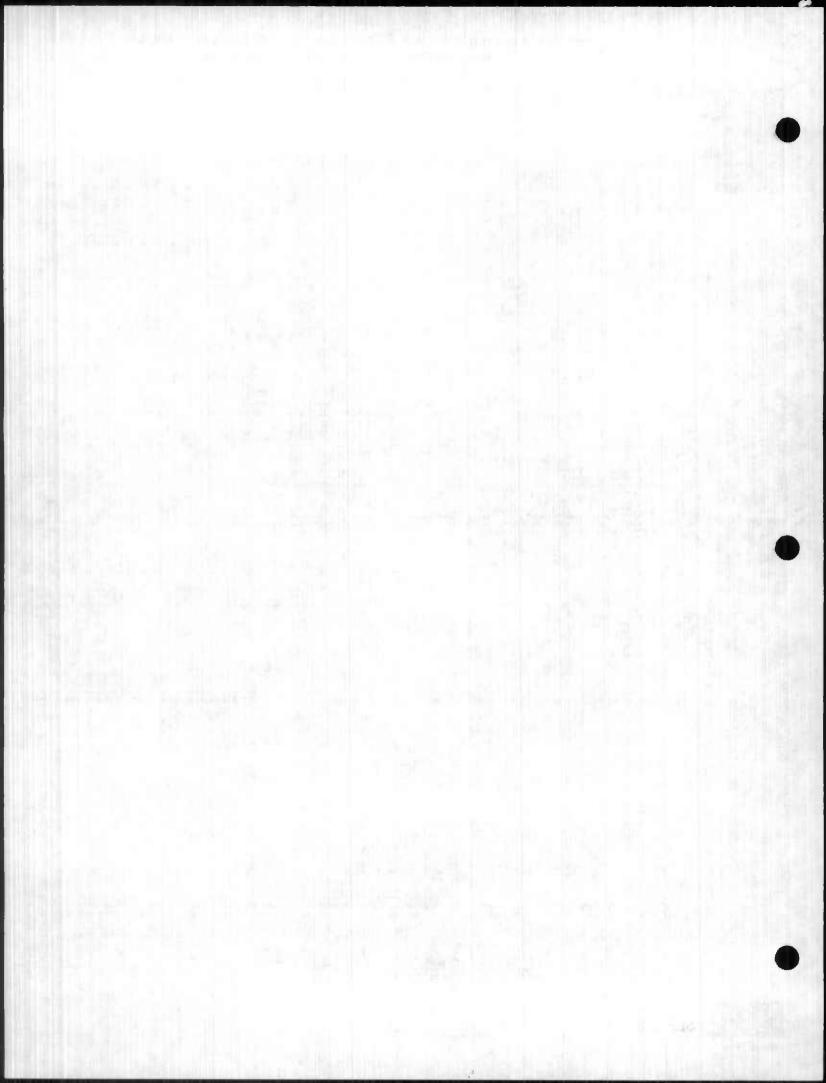
BALTIMORE

29c. License number

MD 21224

21000

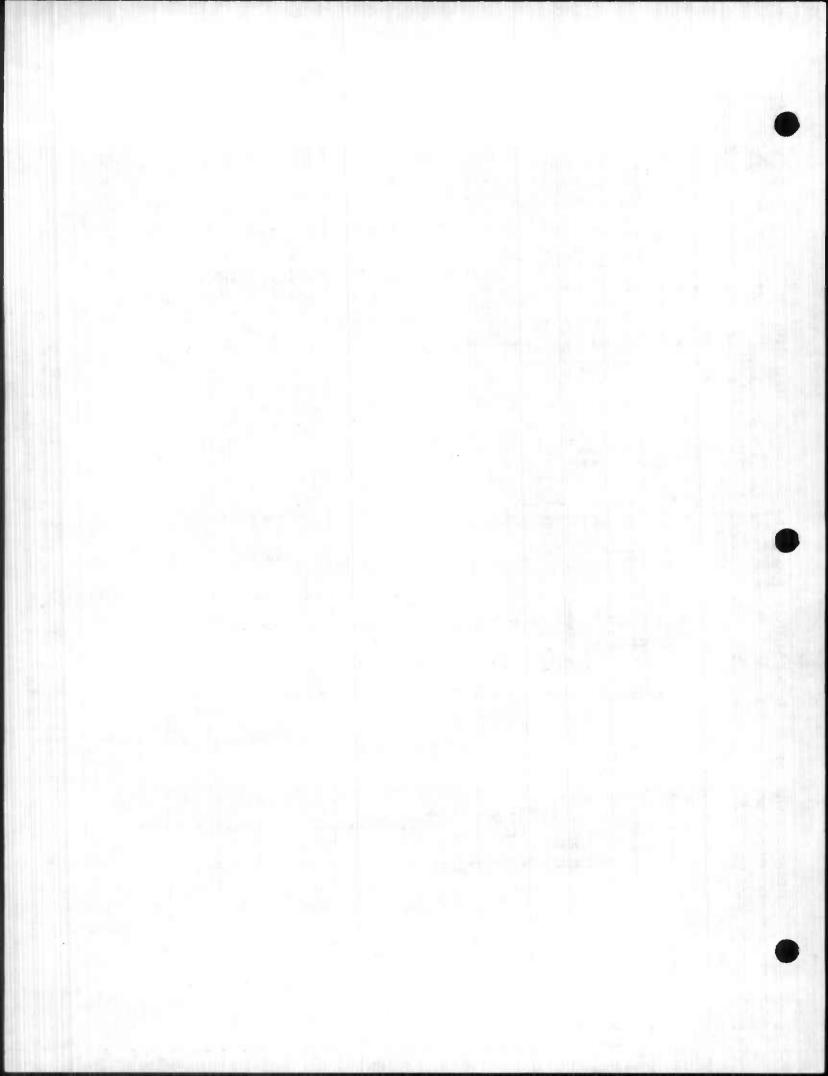
29d. Date signed (Month, Dey, Year)



216-03-8294  1MM 2DF  84  Yrs. Months Days Hours Min. AUG. 19, 1916 MA  Usual Residence of Decedent  10e. State  10b. County  MARYLAND ANNE ARUNDEL  GLEN BURNIE  10f. Zip Code  10g. Citizen of What  10g. Citizen of What  21060  UNITED STA	3:15 A.M. eath RUNDEL Birthplace (State or Foreign Country)  10d. Inside City Limits 1 Yes 2 No  Country?  ATES merican Indian, thite, etc.  HITE pss/Industry
### Facility Name (if not institution, give street and number)  101 SUMMIT AVE., APT. C  5. Social Security Number 216-03-8294   12 M 2   F	RUNDEL Birthplace (State or Foreign Covolny) ARYLAND  10d. Inside City Limits 1 Yes 2 No  Country? ATES merican Indian, thite, etc.  HITE pss/Industry
216-03-8294   1\overline{\text{M}}    20   F   84   Yrs.   Moriths   Days   Hours   Min.   AUG. 19, 1916   Mr.	Country ARYLAND  10d. Inside City Limits 1  Yes 2 No  Country?  ATES merican Indian, hite, etc.  HITE sss/Industry  AL
10a. State 10b. County 10c. City, Town or Location GLEN BURNIE  10e. Street and Number 101. Zip Code 201. Zip Zip Code 201. Zip Zip Zip Zip Zip Zip Zip Zip Zip Zip	1 Tyes 2 No Country?  ATES merican Indian, thite, etc.  HITE sss/Industry  AL
101 SUMMIT AVE., APT. C  11. Marital Status  1 Never Married 2 Married 3 Middwed 4 Divorced  12. Was Decedent Ever in U.S. Amed Forces? 1 Middle, Last)  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use relived)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)  19a. Informant's Name/Relationship (Type, Print)  WILLIAM J. SHUE, JR./SON  20a. Method of Disposition 10 Sepocity:  20b. Place of Disposition (Name of complete)  20c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use relived)  18b. Mailing Address (Street and Number or Rural Route Number, City or Town, State of Disposition (Name of complete)  20b. Place of Disposition (Name of complete)  20c. Location - City (CEDAR HILL CEMETERY)  20d. Detail of Sepocity (Sepocity)  22c. Name and Address of Facility	Country? ATES merican Indian, fhite, etc. HITE sss/Industry AL
101 SUMMIT AVE., APT. C  11. Marrital Status  1 Never Married 2 Married  3 Middle deprived  1 Middle Last)  1 Seedent's Decedent's Usual Occupation (Specify only highest grade completed)  1 New First, Middle, Last)  1 LAWRENCE SHUE  1 Shuffled Shuffle, Last)  1 Shuffled Disposition  1 Shuffled Disposition  1 Shuffled Disposition  1 Shuffled Disposition  1 Shuffled Disposition  2 Shuffled Disposition  2 Shuffled Disposition  2 Shuffled Disposition  2 Shuffled Disposition  2 Shuffled Disposition  2 Shuffled Disposition  3 Removal from State  4 Shuffled Shuffled Shuffled Disposition  2 Shuffled Disposition  2 Shuffled Disposition  2 Shuffled Disposition  2 Shuffled Disposition  2 Shuffled Disposition  2 Shuffled Disposition  3 Removal from State  4 Shuffled Shuffled Shuffled Shuffled Disposition  5 Shuffled Disposition  2 Shuffled Disposition  2 Shuffled Shuffled Shuffled Shuffled Disposition  4 Shuffled Shuffled Shuffled Shuffled Shuffled Shuffled Disposition  2 Shuffled Shuffled Shuffled Shuffled Shuffled Shuffled Disposition  2 Shuffled Shu	ATES merican Indian, /hite, etc.  HITE ess/Industry
11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  1 Never Married 2 Married 1 Never Married 2 Married 3 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 4 Never Married 3 Never Married 4 Never Married 5 Never Married 5 Never Married 6 Never Married 7 Never Married 8 Never Married 8 Never Married 8 Never Married 9 Never M	merican Indian, /hite, etc. HITE sss/Industry
Specify: Will   1   1   1   1   1   1   1   1   1	AL
17. Father's Name (First, Middle, Last)  LAWRENCE SHUE  19a. Informant's Name/Relationship (Type, Print)  WILLIAM J. SHUE, JR./SON  20a. Method of Disposition 15 Burjat 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  18. Mother's Name (First, Middle, Maiden Surmame)  (UNKNOWN)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 301 NEWFIELD RD., GLEN BURNIE, MARYLANI  20a. Method of Disposition 15 Burjat 2 Cremation 3 Removal from State CEDAR HILL CEMETERY  20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City 20c. Location - City 20d. Place of Disposition (Name of cemetery, cremetory or other place) 20d. Place of Disposition (Name of cemetery, cremetory or other place) 20d. Place of Disposition (Name of cemetery, cremetory or other place) 21. Signature of Europe Service Litensee	AL
17. Father's Name (First, Middle, Last)  LAWRENCE SHUE  19a. Informant's Name/Relationship (Type, Print)  WILLIAM J. SHUE, JR. / SON  20a. Method of Disposition  1 Burjal 2 Cremation 3 Removal from State  4 Donation 5 Removal from State  21. Signature of Euraha Service Licensee  18. Mother's Name (First, Middle, Maiden Surname)  (UNKNOWN)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State  301 NEWFIELD RD., GLEN BURNIE, MARYLANI  20b. Place of Disposition (Name of cemetery, cremetory or other place)  CEDAR HILL CEMETERY  2000 BROOKLYN  222. Name and Address of Facility	
LAWRENCE SHUE  19a. Informant's Name/Relationship (Type, Print) WILLIAM J. SHUE, JR./SON  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State WILLIAM J. SHUE, JR./SON  20a. Method of Disposition 10 Burjal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, cremetory or other place) CEDAR HILL CEMETERY  20c. Location - City CEDAR HILL CEMETERY  20d. BROOKLYN  21. Signature of English	e, Zip Code)
WILLIAM J. SHUE, JR./SON  301 NEWFIELD RD., GLEN BURNIE, MARYLAN  20a. Method of Disposition  120 Burjal 2 Cremation 3 Removal from State 4 Document (Specify)  20b. Place of Disposition (Name of cemetory or other place)  CEDAR HILL CEMETERY  21. Name and Address of Facility	e, Zip Code)
20a. Method of Disposition  1 No Burgat 2 Cremation 3 Removal from State 4 Doubtion 5 Chart (Specify)  20b. Place of Disposition (Name of cemetery, cremetory or other place) CEDAR HILL CEMETERY  20c. Location - City SEPT. 19 20c. Location - City CEDAR HILL CEMETERY  21. Signature of European Service Licenses	D 21060
21. Signature of Europeal Service Licensee 2 22. Name and Address of Facility	or Town, State
KIRKLEY-RUDDICK FUNERAL HOME. P.A.	PARK, MD
421 CRAIN HWY., S.E., GLEN BURNIE, N	MD 21061
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line.  Immediate Cause (Final	Approximate Intervel Between Onset and Death
Immediate Cause (Final disease or condition resulting in deeth)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events)	Sysais
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Ischemic Candra uny dar files  Due to (or as a consequence of):  Curandly flash Sissand  Due to (or as a consequence of):	13 years
	12 years
Possuring in death) Last	20 years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.  1	uta to the cause of death?
# Htmal Falmellation 10/400 20 No 30	Probably 4 Unknown
	lb. Wera autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No	1 Yes 2 No
25. Was case referred to medical axamine?	
1 Inpatient 2 LEHVOutpatient 3 LDOA 4 Li Nursing Home 5 M Hesidence 6 Li Other (S	Specify)
27. Manner of Death 1 Natural 1 Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day Year) 28b. Tima of Injury Work? 1 Yes 2 No  28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred	r Rural Route Number,
29a. Certifier (Check only)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.  29b. Signature and fille of certifier  29c. License number  29d. Date signed (M	r as stated.
and manner stated.  29c. License number  29d. Date signed (M	
H 17744 SEPTEMBER	R 18, 2000
DAVID A. SCHWARTZ, D.O., 300 HOSPITAL DRIVE, GLEN BURNIE, MARYLAND 2106	
State 31. Data filed (Month, Day, Year) 32. Registrar's Signature (SFP 1 8 2000) Server & Signature	51

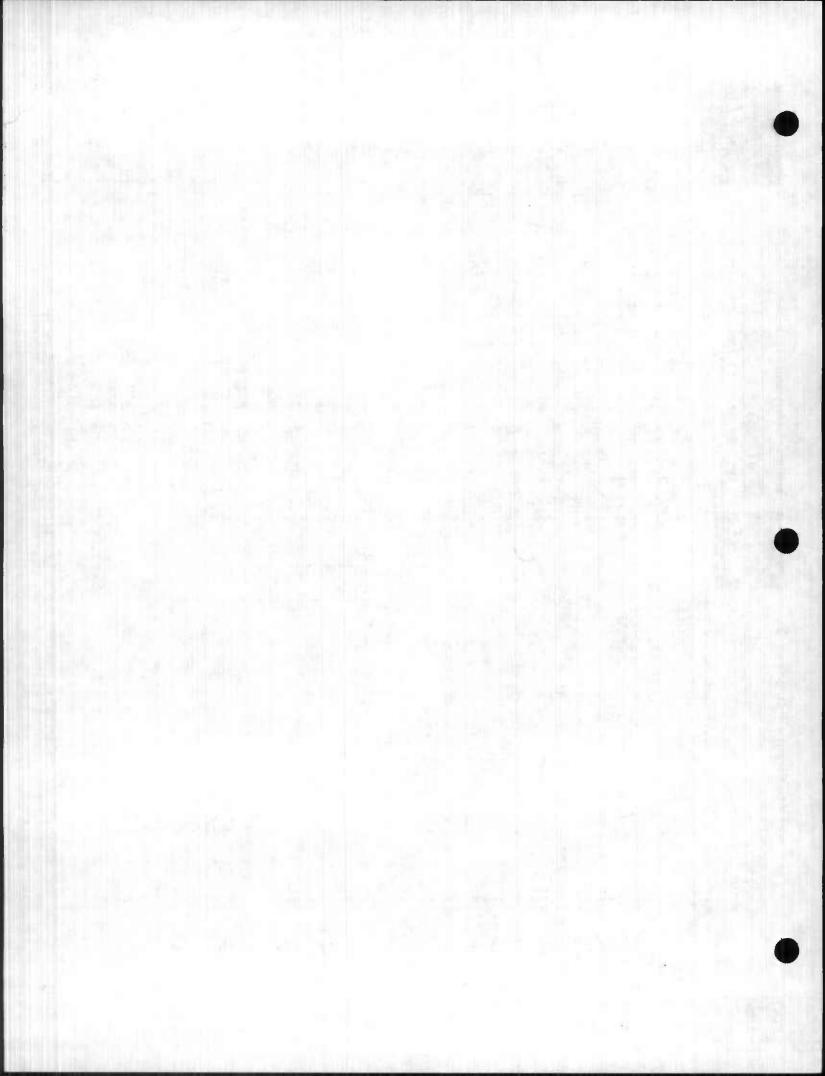
DHMH 16 Rev 6/95

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene 0 29364

Certificate of Death	Reg. No.	23304
1. Decedent's Name (First, Middle, Last)  2. Data c	Death Day	3. Time of Death
Medical LAWRENCE DUVALL STAFFORDSKSEP	1.072	000 12:309
xaminer 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of C		of Death
3700 GREENSPRING AVENUE BALTIMA		NA
5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Data of Months 1 Days Hours Min. (Months Days Min. (Months Days Months Days Months Days Months Days Min. (Months Days Months Days Min. (Months Days Months Days Months Days Min. (Months Days Months Days Min. (Months Days Months Days Months Days Min. (Months Days Months Days Min. (Months Days Months	Birth Day Year) 28, 1953	Birthplace (State or Foreign Country)
	28, 1953	ILLIN015
Usual Rasidence of Decedent  10a. Stata 10b. County 10c. City, Town or Location		10d. Inside City Limits
	-/	Yes 2□No
MARYLAND N/A BALTI HORE C17  10e. Street and Number 100. Zip Code	10g. Citizen of V	Mhat Country?
	/ log. Onzollor	C a
3700 GREENS PRING AVENUE 2/2/5  11. Marital Status 12. Was Decedant Ever In U.S. 13. Was Decedent of Hispanic Origin? (Specify Yas of	No- 14 Rac	e - American Indian,
11. Marital Status  12. Was Decedant Ever In U.S. Armed Forcaş?  1 □ Nevar Married 2 ☑ Married  1 □ Yes 2 ☑ No	Biac	ck, Whita, atc.
If Yes, Give 1 ☐ Yas 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Specify	BLACK
15. Decedent's Education 16a. Decedent's Usuai Occupation	16b. Kind of Bu	usiness/Industry
(Specify only highest grada completed)  (Giva kind of work dona during most of working life. DO NOT use retired)  (Flementary/Secondary (0-12) College (1-4or 5+)		
12+4 GRADE CONSTRUCTION WORKER	BALTO	CITY GOVERNMEN
17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Last)	idia, Maidan Sumam	na)
15. Decedent's Education (Specify only highest grada completed)  Elementary/Secondary (0-12)  16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired)  CONSTRUCTION WORKER  17. Fathar's Nama (First, Middla, Last)  18. Mothar's Nama (First, Middla, Last)  STAFFORD ANNA MI	HE Y	ZURIFOI
19a. Informant's Name/Ratationship (Type, Print)  19b. Mailing Address (Street and Number or Rurel Routa N	imber, City or Town,	Stata, Zip Code)
ANNA MAE STAFFORD (MOTHER) 7/11 GREENWAY AVE., 1	HILADELA	HA PA 19142
20a. Mathod of Disposition  20b. Place of Disposition (Name of cematary, crematory or other placa)	20c. Location -	City or Town, Stata
4 Donation 5 Other (Specify) MT, ZION CEMETERY 9-13-	DLANSI	MUNE HARVLA
21. Signature of Format Service Licenses  22. Nama and Address of Facility  JOSE PH H. BROW	W. TP Fr	INFRAI HOM.
2140 N. FULTON AV	- BOLT	MODE IN SIDI
23a Part1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respirations, or heart failure. List only one cause on each line.	ry arrest,	Approximata
snock, or naart tailura. List only ona causa on aach lina.		Interval Betwaen Onset and Death
immediate Cause (Final disaasa or condition and a condition an		minutes
rasulting in death)  a.  Dua to (or as a consequence of):		100
Rulmonary Fibrosis		4-Syear
Sequentially list conditions,  Due to (or as a consequence of):		
Sequentially list conditions, if any, taading to immediate cause. Enter Undertying Cause (Disease or injury c.		
Cause (Disease or injury that initiated evants resulting in death) Last  Due to (or as a consequence of):		
		i
Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part t.  23b.		
Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b.		ntribute to the cause of death?
Sepsis	1 Yea 2 No	3 Probably 4 □ Unknow
240	Was an autopsy	24b. Ware autopsy findings
End Steige Renal Disease	performed?	availabla prior to completion of cause
End Steige Renal Disease	\	of death?
	Yas 2 No	1 ☐ Yes 2 No
25. Was case referred to medical examinar?  Hospital: Other: Other: Other:		
1 Linpatient 2 LEW Outpatient 3 LOOA 4 Linvaring Homa 32	esidence 6 Oth	
27. Manger of Death 28a. Date of Injury 28b. Tima of Injury at Work? 28d. Description invastigation M Injury M Injury 1   28c. Injury at Work? 1   Yes 2   No	De now injury occur	160
2 Accident investigation 3 Suicide 6 Could not be determined to the could not be determined t	on (Street and Numb	ber or Rural Route Number,
	Town, State)	
29a. Cartifier To tha best of my knowledge, death occurred at the time, date and place, and due to	the cause(s) and mi	annar as stated
27. Manger of Death 2 Naturat 2 Accidant 3 Suicida 4 Homicide 28e. Place of Injury - At home, farm, street, factory, offica	me, date and place,	and due to the cause(s)
29b. Signature and the of sentior 29c. Licanse number	29d. Data signe	ed (Month, Day, Year)
MISIEUS NUO DUTILL	9/1-	3/10
17110	1//	700
30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print)  Donna - Leina win Whiv. & Many land. 22 S. E.	round Ci	L Baltimore,
21 Date filed (Afanth Day Voor) 20 Basistada Signatura	, 0,00	MO 91701
e 31. Date filed (Month, Day, Year) 32. Registrar's Signatura		



Plea	se Type or State o						II Copies A		_	29365
			Cer	tificate o	of Dea	th	R	eg. No.		
Decedent'a Name (First, Middle RUTH	a, Last) ARLE	NE		SCHEMM			2. Date of Dear Month SEPTEMB	Day	Year 2000	3. Tima of Death 4:35 PM
4a Facility Name (If not institution	n, give street and nu	mber)			4b. Cit	y, Town, or L	ocation of Death		y of Death	
FUTURE CARE CH					Δ	RNOLD		ANNE	ARIINI	DEL.
5. Social Security Number	6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Ya	ar If U	ndar 24 Hra.	8. Date of Birth		9. Birth	plece (State or Foreign
210-14-5376	1□M 20XF	76	Yrs.	Months Da	ys Ho	urs Min.	AUG . 8		Cou	NSYLVANIA
Usual Residence of Decedent										
10a. State 10b. County		10c.	City, Town or Lo	cation						10d. Inside City Limits
MARYLAND ANNI	E ARUNDEL		GLEN	BURNIE	3					1 ☐ Yas XIX No
10e. Street and Number				10f. Zip Cod	0		1	0g. Citizen of	What Cou	ntry?
8108 GLEN HOLI	LOW DRIVE			21	061			U.5	.A.	
11, Marital Statua	12. Was Dec		n U,S.   13. V	Was Decedent	of Hispani	c Origin? (Sp	pecify Yes or No-			can Indian,
1 ☐ Nevar Married 2 ☐ Man	Armed Fo		1941-	Yas, specify C	luban, Me	xican, Puerto	Rican, atc.)	Bia	ick, Whita,	etc.
3 ☐ Widowed 4 X Divorced	If Yes. Gi	Ve	1946	□ Yes 2∏	No Spe	ocify:		Speci	ty: WHI	re
	it's Education st grade completed)		16a. Deced	lent's Usual Oc kind of work do	ne during	most of work	king	16b. Kind of I	Business/Ir	ndustry
Elementary/Secondary (0-12)	College (	1-4or 5+)		OO NOT use re	tirea)			WESTI	NCHOI	TSF
12			SECRE	TAKI						) DE
17. Father's Nama (First, Middle,	Last)						ne (First, Middle, I	Maiden Suma		nep.
THOMAS		DAVID	SON		S	TELLA			LES!	LEK
19a. Informant's Name/Relations MR. ROBERT SCI		SON)					ral Route Number			
20a. Method of Disposition	(1		b. Place of Dispo	sition (Neme o	f			20c. Location		
1 X Burlal 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			cemetery, cren EFFERSON			9	9/18/2000 I	) PITTSBU	JRGH,	PA.
21. Signature of Funaral Sensition	tionento						GLETON I			
23a. Pert1. Soter the disease, or shock, or heart feilura. List	cen blicetions that only one cause on	caused the deach line.	eath. Do not ente	er the mode of	dying, suc	ch as cardiac	or respiratory arr	est,		Approximate Interval Between Onsat and Death
Immediate Causa (Finel diseasa or condition	0	Lems	Can	cor						6 months
rasulting in death)			o (or as a conseq							
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseasa or Injury	b	Dua te	o (or as a conseq	juence of):						
that initiated events resulting in death) Last	c.	Dua to	o (or as a conseq	uence of):						
Part II. Other significant condition	ons contributing to d	eath but not	resulting in the un	nderlyina cause	given in	Part I.	23b. Did to	obacco usa c	ontributs	to the cause of death?
								'es 2□ No		obably Allunknown

Physician /Medical Examiner

**Physician** 

/Medical-

Examiner

**Funeral** Director

"natural", or leans 23s or 28s-f show adical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mertal Hygiens. Improvisert: If Itam 27 is marked other than "natural", or Itam any Injury or other traumatic event, the Medical Examiner applica.

Baltimore, Maryland 21215-0020

Duth.

Director

To Be Completed by Funeral

To the Hospital or Attending Physician: The law within 24 hours after death.

Or the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2. Medicai Certification: To

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

Be Completed by Physician/Medical Examiner

is certificate has been signed by the attending physician and director, page 2 should be deteched for use as the burial-transit

3 Suicide

29e. Certifiar (Check only one)

4 Homicide

29b. Signature and title of certifier

26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Othar (Specify)

25. Was case referred to medical examiner? Hospitel: 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 5 Pending investigation 1 Natural 2 Accident

6 Could not be determined

28c. Injury at Work? 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

140519

29c. License number

Picertifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Suite 200, Colon Guene, 2061.

24a. Was an autopsy performed?

1 Yes 2 Daylo

28d. Describe how injury occurred

24b. Were autopsy findings available prior to

completion of cause of death?

1 Yes 2 No

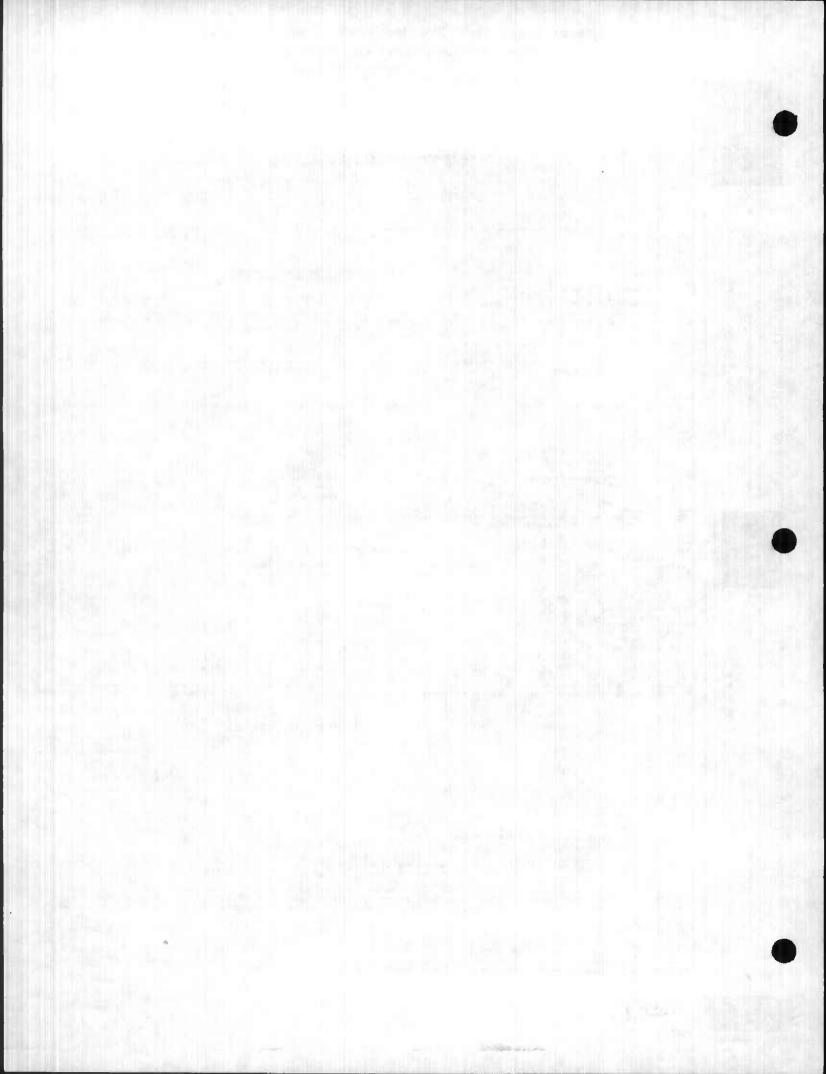
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIRZA M. NUSARES 7845

Dakwood Prof, oaks

31. Data filed (Month Pay, Year) State Registrar

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death Da SCHAFFLE SEPENBER 16, 2000 FOWARD 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Nama (If not institution, give street and number) Northwest Hospital Center Randallstown Baltimore | If Undar 24 Hrs. | 8. Data of Birth | 9. Birthplace (State Month, Day, Yaar) | 9. Birthplace (State Country) | March 10, 1923 | Maryland If Under 1 Year 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number Days 10M 20 F Months 216-16-1262 Yrs. Usuel Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Md. Baltimore Reisterstown 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? U.S.A. 235 Chartley Drive 21136 12. Wes Decedant Ever in U,S. Armed Forcas? 1 ☑ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specity Yas or No-if Yes, specify Cuban, Maxican, Puerto Ricen, atc.) 14. Race - American Indien. 11. Maritai Stetus Bleck, Whita, atc. 1 Navar Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) Collega (1-4or 5+) Telephone Co. Field Engineer 18. Mothar's Nama (First, Middla, Maiden Sumame) 17. Fathar's Nema (First, Middla, Last) Jenny Hopkins Schaffle 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 235 Chartley Drive, Reisterstown, Md. 21136 Jeanette Schaffle - Wife 20e. Method of Disposition

1 Buriai 2 Cramation 3 Ramoval from State 20b. Pleca of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata Metro Crematory Sept. 18,2000 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility
Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 23a. Part F. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or head failure. List only one cause on each line. Approximate Interval Batween Onsat and Death Immediata Causa (Final disaasa or condition rasulting in death) nsaquance of): weenone Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or as a consequence of) Dua to (or as a consequence of): 23b. Did tobseco uss contributa to the causs of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yss 2 No 3 Probably 4 Unknown HTN, Das 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 20 M t ☐ Yas 2 No 26. Placa of Death (Check only ona) Hospitai: Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 12 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of 5 Panding 1 Yas 2 No

Examiner ettending physicien and for use es the bunal-transit requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. 98 the 3 signed ! peen aw. 785 The certificate Physicien: this funeral After or Attending s after death.

I Director: After din by the fundamental of the fundam within 24 hours a To the Funerel C Hospital pletely

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "naturel", or items 23s or 28s-1 show

permit. Peges 1 and 2 should be filed within 72 hours effer death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or flarm 23a and Injury or other traumatic event, the Medical Examine man and page.

**Physician** 

/Medical

Examiner

Physician/Medical

p

Completed

Be

10

Certification:

edical

Baltimore, Maryland 21215-0020

Directo

Funeral

by

Completed

with the Merylend

25. Was casa rafarrad to madical examiner?

1 Yas 2 No 27. Maphar of Death Natural 2 Accident 6 Could not be detarmined 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Spacify) 4 Homicida

29a. Cartifian (Check only one)

1 Cartifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated ninar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceusa(s) and manner stated.

29b. Signature and title of oa

29d. Date signed (Month, Day, Year)

30. Name and address of person who

muland cause of death (itam 23a) (Type, Print)

IMPERIA

Registrar

31. Date filed (Month/Day, Year) 8 2000 SEP

32. Registrar's Signatura

DHMH 16 Rsv 6/95

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.bk , arantfill Doct, 11 . Jest gratemed as to.

# PATIENT KNOWN AS PAULINE SHATTUCK Baltimore, Maryland 21215-0020

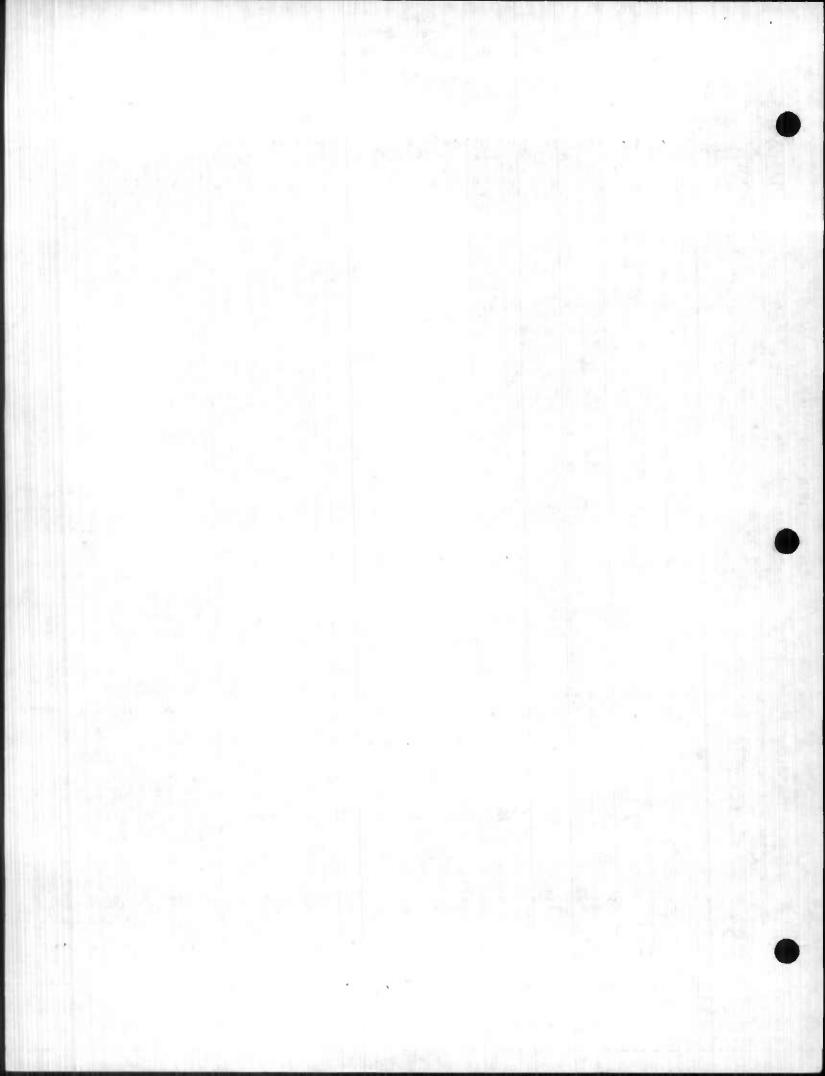
/Medi Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Pureral Director: After this certificate has been signed by the attending physician and commissed silled in by the trinsal director page 3 should be detached for use as the brindstrand Division of Vital Records, P.O. Box 68760,

# Please Type or Print in Black Indelibie ink. Assure Ali Copies Are Legibie.

State of Maryland / Department of Health and Mental Hygiene

				001		Death			Reg. No.		
Physician /Medical	1. Decedent's Name (First, Midd PAULINE A.	INE A. SHATTUCK						2. Date of D Month SEPTEM	BER 1	Year 1 2000	
Examiner	4a Facility Name (If not institution SINAI HOSPITA	The state of the s	1	E		_		E CITY		unty of Dea	th
uneral rector	5. Social Security Number 220-09-2737		Age (In yrs. I		If Under 1 Yes Months Dey		24 Hrs. Min.	8. Dete of B (Month, D July 4	irth (1917)	9. Bir	thplace (State or For ountry) PA
	Usuel Residence of Decedent  10a. State 10b. County		10c City	, Town or Loc	cetion						10d. Inside City Lir
be notified at Director	MD N/		Toc. Ony		imore			1			1)X) Yes 2□
or 2	10e. Street and Number				10f. Zip Code				10g. Citizen	of Whet Co	ountry?
25s	5706 Newholme	Avenue				21	206		I	JSA	
it, or thems 23s or 28e-f sho harriner must be notified at by Funeral Director	11. Marital Stetus  1 Never Married 2 Mai  3 Widowed 4 Divorce	If Yes, Give	S? XI No		Vas Decedent of Yes, specify Cu □ Yes 2X N			ecify Yes or N Rican, etc.)		Black, Whit	ericen Indian, te, etc. Vhite
			S:	10- Doord	tanta Haval Osa				10h Kind	et Pusieens	Andrease.
v. the Medical	(Specify only highe	nt's Education ast grade completed)		(Give )	lent's Usual Occ kind of work don OO NOT use reti	e during mos	st of work	ing	160. Kind	ot Business	zindustry
G 3 0.	Elementary/Secondary (0-12)	Cotlege (1-4	or 5+)	me. L	unk	100)				1-	
fice.  To Be Corr	17. Father's Name (First, Middle,		9		ulik	10 Moth	orlo Nami	e (First, Middl	a Maidan Su	unk	
Be C		300							o, maioeri 30		
To Mile	Jacob Frommeye							raber			
The The	19a. Informant's Name/Relation				g Address (Stre			al Route Num	ber, City or To	own, State,	Zip Code)
other traum	Sinai Hospital				W. Belv	edere	Ave		more,		1215
ury or off	20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (5		00	ace of Dispos emetery, crem	sition (Name of natory or other p	ilace)	1	Date	20c. Locat	tion - City or	Town, State
any inp	21. Signature of Funeral Service Joseph	B. Van Sant				natomy	Boa		5 W. B	altimo	ore Street
	23a. Peli 1. Enter the disease, o	r complications that cause	sed the deeth		Baltimo			201	arrast		Approximate
Examiner Examiner	Immediate Cause (Final disease or condition resulting in death)	a BAC	Due to (or	as a conseq	H-11-	>					48 Hev
	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events	с	· ·	as a conseq	1 1						
	resulting in death) Last	L d	Due 10 (01	es a consequ	uenca oty.						
d for	Part II. Other significant conditi	ons contributing to deat	but not resu	ilting in the ur							
5 5					nderlying cause	given in Part	L	23b. Di	d tobacco us	e contribut	e to the cause of de
y Phy	ATRIAL FIR						1.		d tobacco us		e to the cause of de
2 should be detached for upleted by Physician	ATRIAL FIR			Ac			I.	1 [ 24a. Wa		No 3□F	
age 2 should be detac				Ac			I.	24a. Wa	Yes 2	No 3□ F	Probably 4 Unk  Were autopsy finding available prior to completion of cause
N Q	CEREBRAL	Vascula-		Ac		Τ		24a. Wa per	Yes 2 Yes 2 X	No 3□ F	Were autopsy finding available prior to completion of cause of death?
lirector, page 2 should be detac o Be Completed by Phy	CEREBRAL  25. Was cese reterred to medical examiner?	VASCULATION Magnitude	NUZ		CIDEN	26. Plac	se of Deal	1 C 24a. Wa per 1 C	yes 2x an autopsy formed?  Yes 2x (ne)	No 3□ F 24b.	Probably 4 Unk  Were autopsy findir available prior to completion of cause of death?  1 Yes 2 No
s funeral director, page 2 should be detacted and the state of the sta	25. Was cese reterred to medical examiner?  1 Yes 25 No  27. Manner of Death  1 Natural 5 Pendi	Hospital: 120np	nuruz_	ER/Outpatien 28b. Tima ot fnjury	CIDEN	26. Plac	e of Deal	24a. Wa per	s an autopsy formed?  Yes 2 Ar one) sidence 6 [	24b.	Probably 4 Unk  Were autopsy findir available prior to completion of cause of death?  1 Yes 2 No
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**DHMH 16 Rev 6/95** 

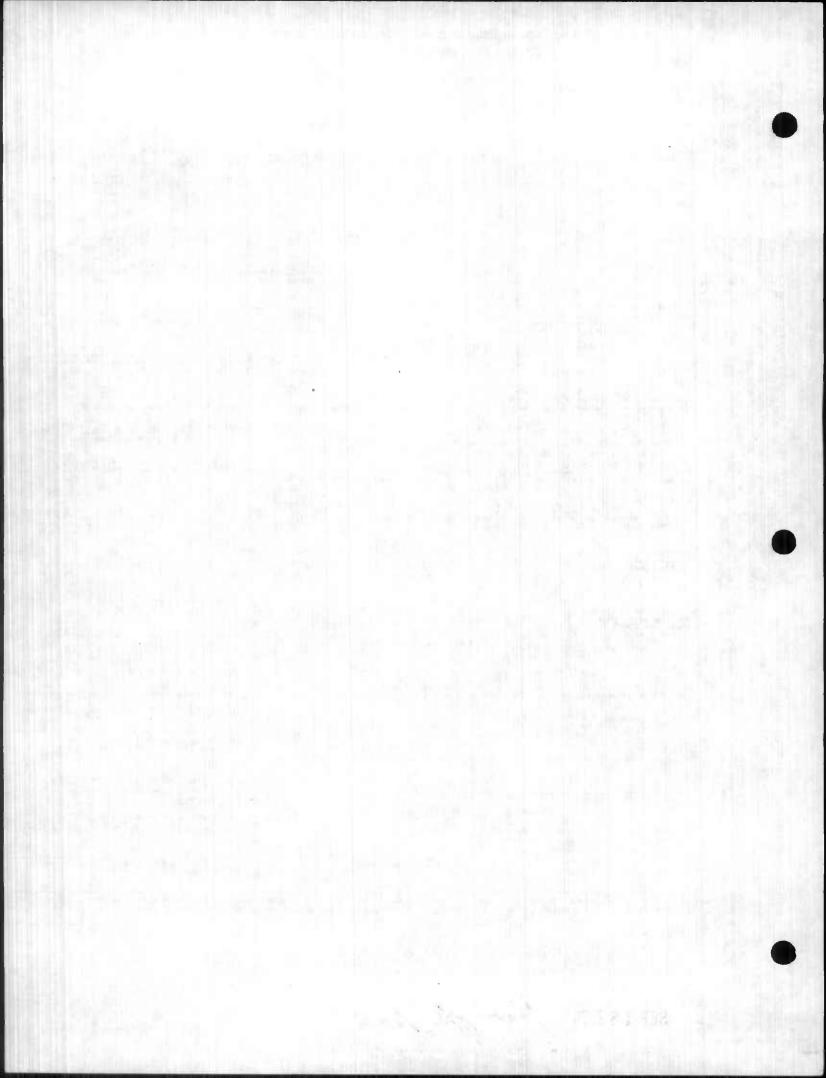


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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				Certifica	te of	Death		Reg	. No.		
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Physician /Medical	Joseph F	STELL VIII	Swan	an				eptember	10	2000	11:40 A.
Examiner	4e Facility Neme (If not institution, giv	e street and number)			- 11			tion of Death	4c. County		
	VAMHCS FORT HOWARD			- I Will-d		FORT I				IMORE	
Funeral	5. Social Security Number 6. S	ex 7. Age	(In yrs. last birt	Months	Deys	If Under a	Min.	. Date of Birth (Month, Day, Y		9. Birthpi Coun	lace (State or Foreig try)
Director	214-36-3124 Usual Residence of Decedent		60	113.				4-25-4	0	Mar	yland
D M	10a. State 10b. County	100	10c. City, Town	or Location						1	0d. Inside City Limits
the Marylar 28a-f show novilled a	Delaware		De1ma	~							1 AYes 2 No
or 284	10e. Street and Number		DeTIIIa		ip Code	47.10		100	. Citizen of \	What Coun	try?
office death with the Ma free reasts or 28e-1 s free ment to notified Funeral Director	372-04 Rural	Rt. 2			10	940			U.S		
ter deal	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U,S.	13. Was Dec			gin? (Speci	fy Yes or No- can, etc.)	14. Rac	a - Americ	
DOZO	1 Never Merried 2 Married 3 Widowed 4X Divorced	12∑ Yes 2 N If Yes, Give Year or Detes:			2 <b>25</b> No	Specify:	, 1 3010 1 1	Jan, 5,5,7	Specify	7.17.	nite
Ind 21215-002 be filed within 72 hours lail Hygiene. d other than 'naturel', avent, in a second Ex-	15. Decedent's Ed (Specify only highest gra		16a.	Decedent's Us	ual Occup	ation	of working	16	b. Kind of B	usiness/Ind	Justry
121 Ben 'r	Elementary/Secondary (0-12)	College (1-4or 5	+)	(Give kind of w life. DO NOT	use retired	9)	or working				
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Baltim permit. Pag Department Important: I any Injury o	4 Donation 5 Other (Specification 21. Signature of Funeral Service Licer		Garri	son Fo		V A		/15/000	wings	M1]	lls, MD
Balt Permit. Depart Importa	21. Signature of Function Service Electron	. 00		Irv	in (	Carro	11 F	uneral	Home	2	
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Chunisian	23a. Part1. Enter the diseese, or com shock, or heart failure. List only	one cause on each lin	10.			·g, •a•, •a•		, copilatory all co			Approximate Interval Between Onset and Death
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Examiner	disease or condition resulting in death)	a	CEREBELI  Due to (or as a c			IFARC1				1	
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68760, ficate be executed physician and is the burial-transit edical Examiner	b. Due to (or as a consequence of):										
68760, rificate be executed up physician and as the burial-transi	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events  Due to (or as a consequence of):  INSULIN DEPENDENT DIABETES MELLITUS  C.  Due to (or as a consequence of):								i		
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the a dec yslc yslc	Part It. Other eignificant conditions of	ontributing to death bu	at not resulting in	the underlying	cause giv	en in Part I.		23b. Dld tob	acco uee co	ntribute to	the cause of death
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On ding	1 Netural 5 Pending 2 Accident investigation		Year) to	njury M		rk? Yes 2⊡l	No				
OlvIsion of Vital Records, or Attending Physician: The law requires the after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by ertification: To Be Completed by	3 Suicide 6 Could not b	9 28e. Placa of tnje	ury - At home, fa	rm, street, facto	ory, offica		28			ber or Run	al Route Number,
Div dint	4 Homlcide	building, etc	:. (Specify)					City or Town,	State)		
Division of To the Hospital or Attending Pt within 24 hours after death completely filled in by the funera Completely filled in by the funera Medical Certification:	29e. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the best of niner: On the besis of and manner ste	examinetion and	, deeth occurre d/or investigation	d at the ti	me, dete an opinion, dea	d place, en th occurred	d due to the cau d at the time, det	use(s) and m e end place,	anner as s and due to	tated. o the cause(s)
Me of the omple	29b. Signature and title of certifier	a de la constante de la consta	^	2	9c. Licens	e number		29	d. Date signe	ed (Month,	Dey, Year)
- 5 - 0	Shen At	zal He	Shu	1 1	02	46	48	9	-10	-9	000
)X	30. Name and address of person who	completed cause of d	eath (Item 23a) (	Type, Print)						OC	
OBO	SHER HASHMI, M.D.		RTH POIN	T ROAD,	FOR	T HOW	ARD, I	MD 21052	2		THE REAL PROPERTY.
State	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature —	-1.							
Registrar	SEP 1 8 2000	Deplan	A.	boars	2/						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Deeth Month Day Year SEPTEMBER 14, 2000 **Physician** E. SCHLOSSBERG ALICE 7:25 AM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner JEWISH CONVALESCENT & NURSING HOME BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Min 1 M 2 ₹ F Days Hours 217-38-2722 Yrs 95 DEC.10,1904 Director MD Usual Residence of Decedent 10a. Stefe 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE or harns 23a or 28a-f the Medical Examiner must be notifi-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8202 ANDES COURT 21208 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11 Maritel Stefus Black, Whita, etc. 1 ☐ Yes 2 XNo If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: WHITE Specify: by 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry should be filed within al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mental marked ISAAC MAZOR REBECCA MARKMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 GILDA WEINFELD / DAUGHTER 8202 ANDES COURT - BALTIMORE, MD 21208 Health Nem 27 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ъ 1 Bunal 2 □ Cremation 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) 8 BETH TFILOH CEMETERY 9/15/00 WOODLAWN, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility SOL LEVINSON & BROS., INC. Solot 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last use as the burial-trar Due to (or as a consequence of) The law requires that the death certificate be execu Box 68760 Due to (or as a consequence of): P.O. Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yss 2 No 3 Probably 4 Unknown of Vital Records, P 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Medical Certification: To Be Completed certificate has 25. Was case referred to medical axaminer? 1 Yes 2 LIN 1 ☐ Yes 2 ☐ No or Attending Physician: 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 7 No 1 Inpatient 2 ER/Outpatient 3 DOA this ( 28a. Date of Injury (Month, Day Year) funeral 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. fnjury at Work? After 5 Pending Investigation Division 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) illed in by 4 Thomicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.

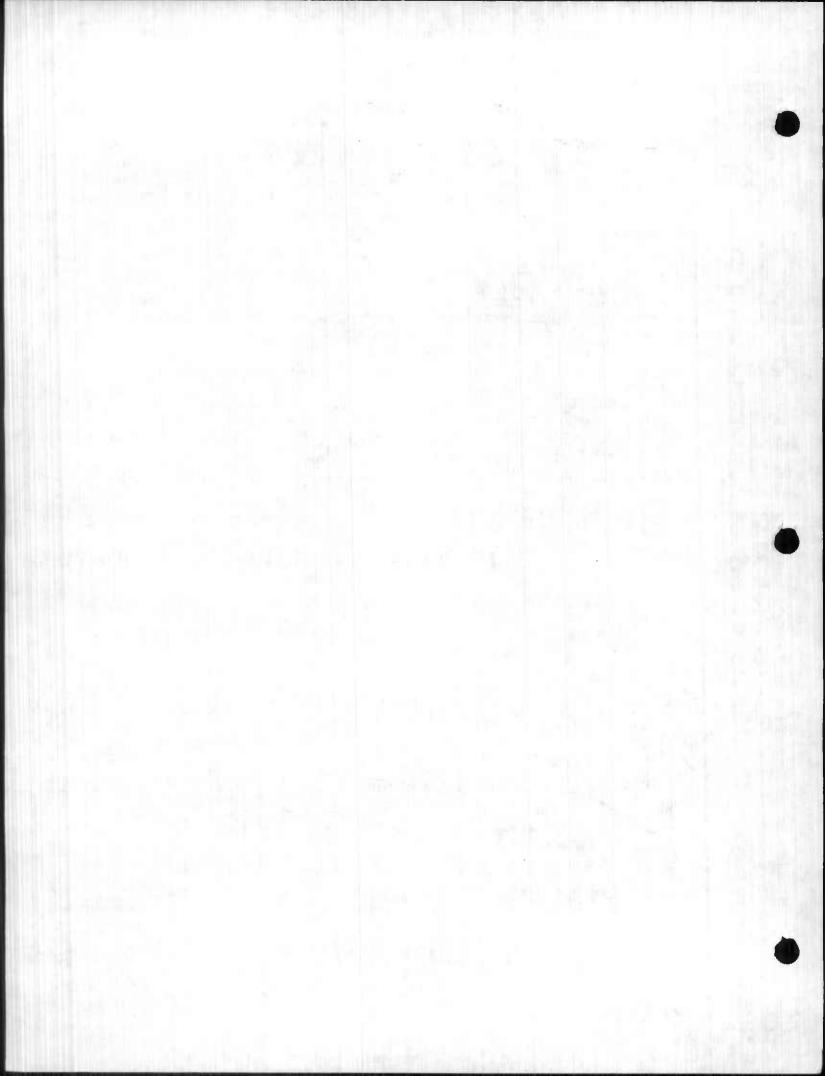
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier completely (Check only one) 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signature and fittle of certifier 30. Name end address of person in who completed cause of death (Item 23a) (Type, Print)

State Registrar

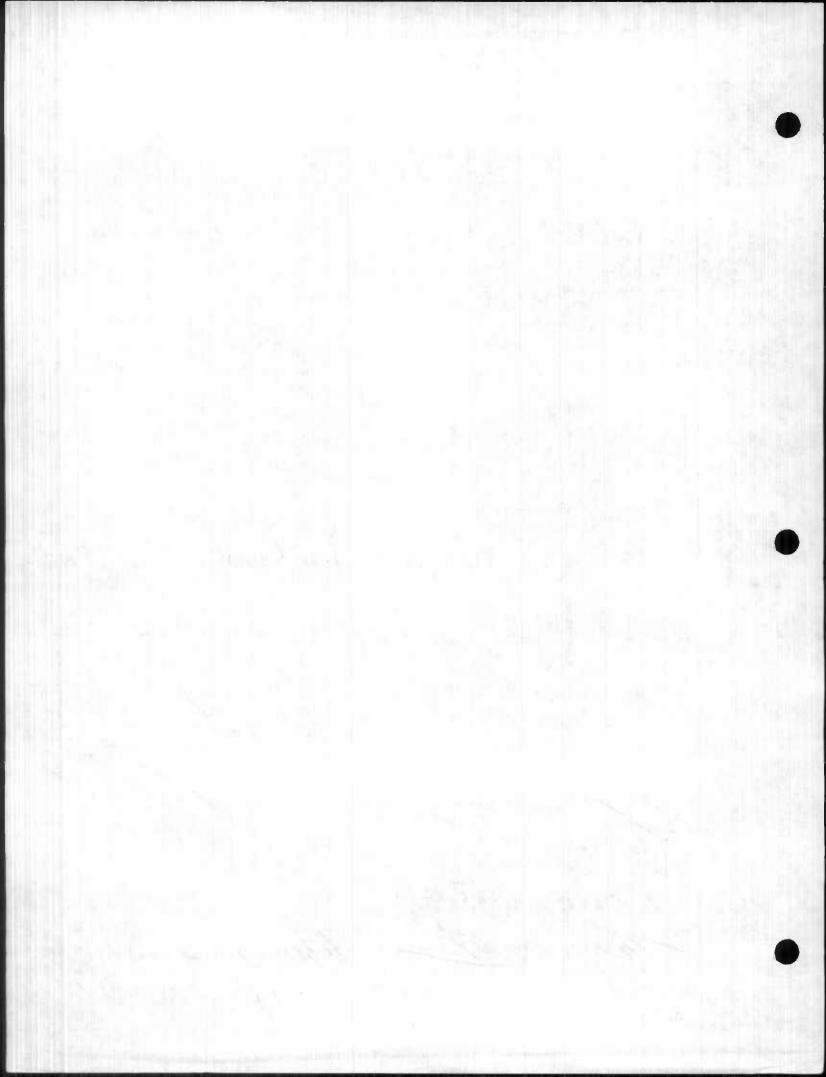
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32. Registrar's Signature



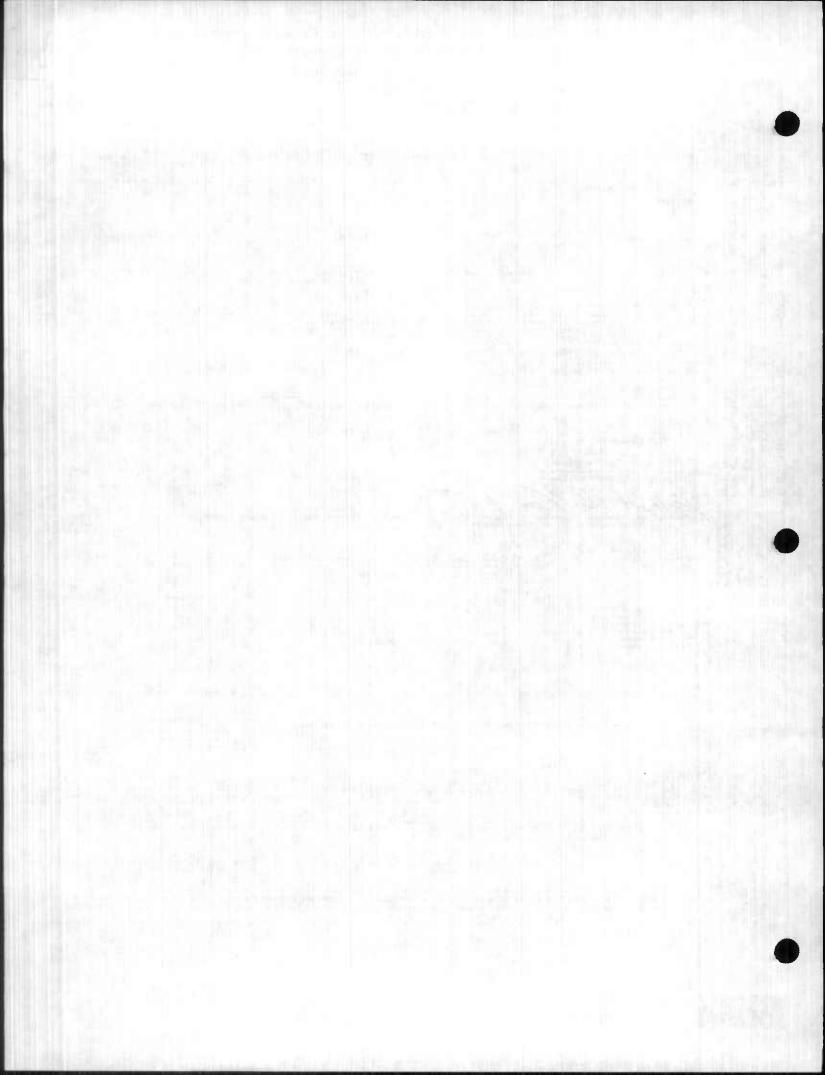
AMEND I	TEM: #12 PER F.H.	State of Maryland G787 9-21-	/ Department of H	lealth and Menta Death	Reg. No.	0 29370			
Physician	RUNALD		TUSK	Mo	te of Death onth Day CPTEMBER 14,2	3. Time of Death Year 000 5:45 AM			
/Medical Examiner	4a Facility Neme (If not Institution, give s 1388 TEABERRY LANE	treet end number)		6b. City, Town, or Location SEVERN		Death E ARUNDEL			
Funeral Director	5. Social Security Number 6. Sex 176 – 34 – 4065	7. Age (In yrs. Ia:	st birthday) If Under 1 Yeer  Yrs. Months Days	Hours Min (M	te of Birth onth, Day, Year) N. 11, 1945	Birthplaca (State or Foreign Country) PENNSYLVANIA			
ahow ahow	Usual Rasidence of Decedent 10a. State 10b. County	10c. City,	Town or Location			10d. Inside City Limits 1 ☐ Yes 2 🛱 No			
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5 2 2 5		2. Was Decedent Ever in U,S Armed Forces? 1 X Yes 2 □ No 196.5		1144 Iispanic Origin? (Specify Y an, Mexican, Puerto Rican,		S.A.  American Indian, White, etc.			
020 urs s	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 1969	1 ☐ Yes 2 X X Io  16a. Decedent's Usual Occup (Give kind of work done	Specify:	Specify:	WHITE iness/Industry			
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re, Maryland 212 s 1 and 2 should be filed within Health and Mental hygiene. tem 27 is marked other than other traumatic event, the Maryland To Be Comp	JOHN W.	TUSCAN		ANNA	, Middle, Maiden Sumeme, COLAR	IC			
	19a. Informant's Name/Relationship (Type REGINA A. TUSKAN	(WIFE)	19b. Mailing Addrass (Street 1388 TEABERRY	LANE, SEVER	N, MARYLAND	21144			
0 80 = 2	20a. Method of Disposition  1X Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)	emovel from State	ce of Disposition (Name of netery, crematory or other place INGTON NATIONAL		0/2000 Location - C ARLINGT				
Baltim permit. Pa Departmen Important any injury once.	21 Singsture of Filheral Service License		22. Name and Addre	SINGUE	TON FUNERAL GLEN BURNIE				
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DIVI	4 Homicide determined	building, etc. (Specify)	na, farm, streat, factory, office	C	ocation (Street and Number ity or Town, State)				
Division  To the Hospital or Attending I within £4 hours after death.  To the Funeral Director: After completely filled in by the funeral Medical Certification			edge, death occurred at the time on and/or invastigation, in my o	ppinion, daath occurred at t	ha time, data and place, ar	nd dua to the cause(s)			
or with the second	* Ollers	nat	29c. Licens	3155	Septem	ber 14, 1000			
0	30 Name and eddress of person who co	ce, 1600	5. CrainH	ighnay, a	len Burnix	, rd. 21061			
State Registrar	SEP 1. 8 2000	32. Registrar's Signatu	Sporks						



State of Maryland / Department of Health and Mental Hygiene

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Examiner	4a Facility Name (If not institution, give 5609 Columbia Ros			16 14	4b. City, Town, Columb:	or Location of Deal		of Death loward
Funeral	Social Security Number     6. S.	ex 7. Age (In yrs	s. last birthday)	ff Under 1 Year Months Days		Hrs. 8. Date of Bi	rth ev Yearl	9. Birthplace (State or Foreign Country)
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Dir Dir	10e. Street and Number			10f. Zip Code	01011		10g. Citizen of W	
23					21044			SA
r tems 234 iner must	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U,S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? an, Mexican, Pu	(Specify Yes or Nuerto Rican, etc.)		e - American Indian, k, White, etc.
Energy P	3 ☐ Widowed 4 ☑ Divorced	1 🛱 Yes 2 🗆 No If Yes, Give Year or Dates:	50	1□Yes 2⊠ No	Specify:		Specify	black
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net of Heal nr: If item 2 iny or other	20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 🕅 Other (Specify	Removal from State		osition (Name of matory or other pla	ice)	Date	20c. Location -	City or Town, Slate
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						10	Yes 25 No	of death?
certificate rector, pag					26 Diego of	Death (Check only		10103 21200
s certifica director, To Be (	examiner?	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	nt 3 DOA Ot	hor	ng Home 5 ARes		er (Specify)
2 2		28a. Date of Injury	28b. Time o		iry at ork?	1	how injury occur	
ector: After by the funer iffication:	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		rk? ]Yes 2∐No			
rs effer death.  al Director: Affert ed in by the funer: Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	reet, factory, office		28f. Location City or To	(Street and Numb own, State)	per or Rural Route Number,
within 24 hours effer To the Funeral Direcompletely filled in b		ysician: To the best of my kr ninar: On the basis of examin and manner stated.						
outho omple			1	29c. Licen	se number		29d. Date signe	d (Month, Day, Year)
<b>5 ⊢ 8</b>	1 the A	5- m	4 & M	D3	1473		Sept 1	11,2000
	30. Nama and address of person who	completed cause of death (Ite	em 23a) (Type,	Print)	1	115 11 5	1 4.10	21043
1000	PATRYCE A. TOY	E, MD 4565	Hemla	ck Core 1	way &	Micot a	My MO	21072
State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	A	2. 35			

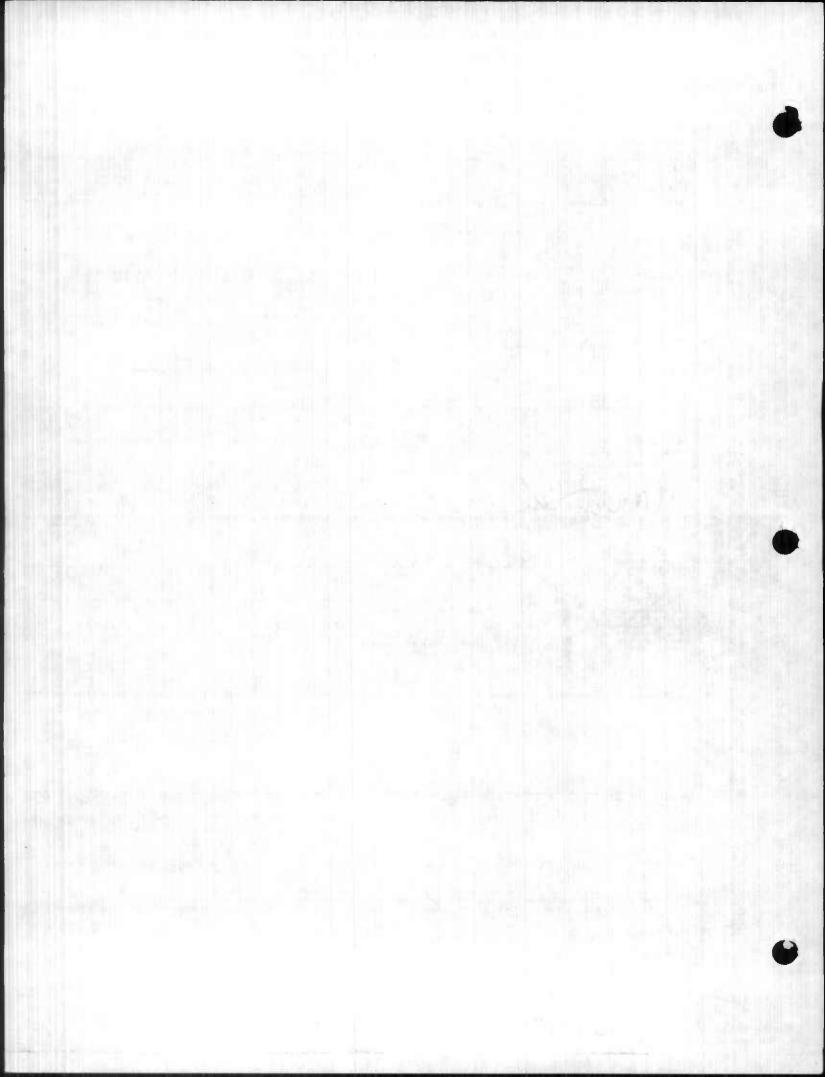


State of Marvland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 10 30/AM **Physician** Willie Nell Wilson SEMEMBER 16,2000 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (II not institution, give street end number) Examiner Stella Maris Hospice @ Mercy Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 10 M 20 F 78 219-18-6631 Director 01-12-22 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f ahow the Medical Examiner must be notified at XXYas 2□ No Director NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21213 USA 1406 N. Bond Street 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Black, White, etc. or Herna 11 Maritel Status filed within 72 hours after I ☐ Yes 2☐ No If Yes, Give X t Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Be Completed by 3 Widowed 4 □ Divorced Black Year or Dates: "naturel". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) Coilege (1-4or 5+) 7th Grade Laborer Beta Shoes i. Peges 1 and 2 should be filed w transt of Health and Mental Hygie tant: if hem 27 is marked other t nlury or other treumatic event, to 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Patmon Frances Patmon John 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 1628 E. Preston Street Baltimore, Maryland permit. Peges 1 and 2 Department of Health a Important: If Item 27 le any Injury or other tree Fannie Middleton 20b. Plece of Disposition (Name of cemetery, cremetory or other pleca) 20a Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from Stete King Mem. Pk. Cemetery 09-20-2000 Randallstown 22. Name end Address of Facility 21. Signature of Funeral Service Licequee Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onsel and Death Physician . Colon Immediate Cause (Finel /Medical disease or condition resulting in death) Examiner Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed Sequentiatly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence ot): Box 68760, Due to (or es a consequença of) USB 85 P.O. I Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown of Vital Records, Be Completed by 24a. Wes en autopsy performed? 24b. Wera autopsy findings completion of cause of death? page 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) STE 1/A Other: 4 Nursing Home 5 Residence 6 Other (Specify) #05 Dice 1□ Yes 25 No Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Medical Certification: To 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Division Natural 5 Pending investigation after death. 1 Yes 2 No 24 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) filled in by 4 Homicide thin 24 hours a To the Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and piece, and due to the cause(s) and menner es steted.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner steted. 29a Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAHIMORE MD 21202 DAVID Ris 30 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar SEP 1 8 2000

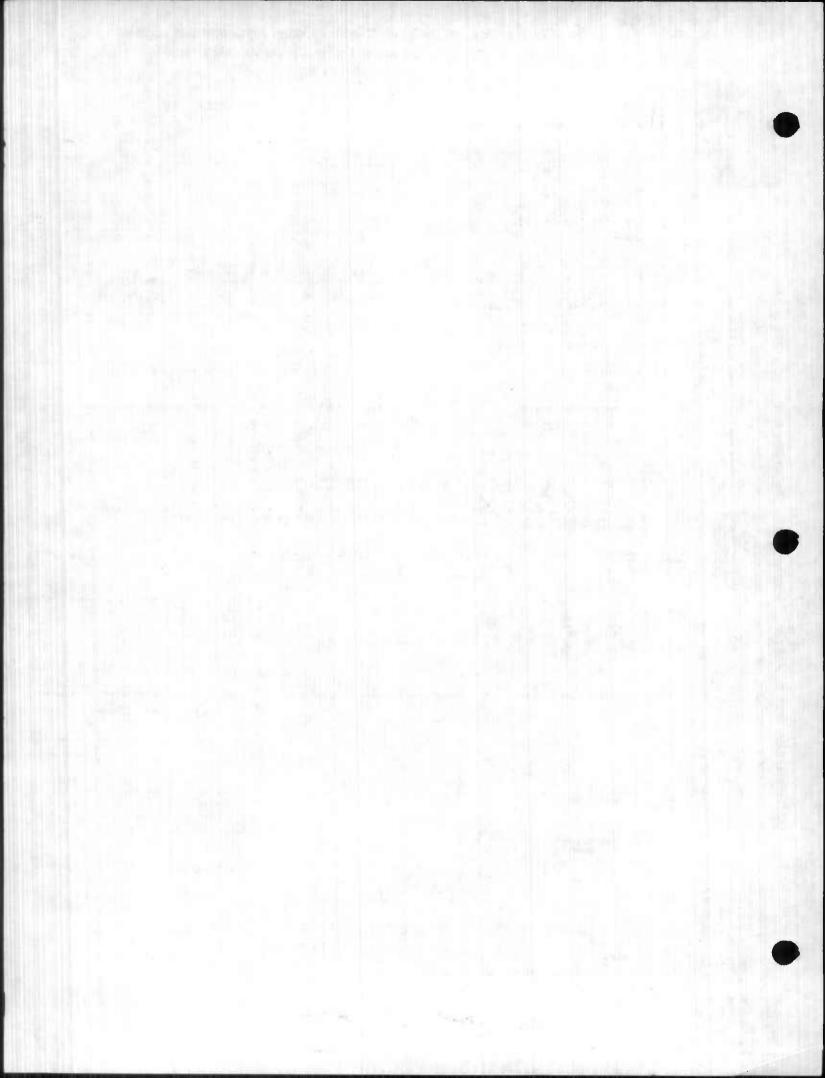
DHMH 16 Rev 6/95

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene #20B PER F.H. G787 9-21-00 WR.

				Ce	entificate	e or	Death			Reg. No.		
Physician	1. Decedent's Name (First, Mi								2. Date of D Month		Year	3. Time of Dear
/Medical	DANIEL DE	AN WALKER	2						EPTEME		2000	4:41 AM
Examiner	4a Facility Name (If not institu	The state of the s	I nu <i>mber)</i>				4b. City, To GLEN		ocation of Dea			RUNDEL
Funeral Director	5. Social Security Number 271-30-8392	6. Sex 12 M 2□ I	7. Age (In 6)	yrs. last birthday 6 Yrs.	Months	1 Year Daya		24 Hrs. Min.	8. Date of B (Month, D FEB. ]	inh Year) 4, 1934	9. Birth Cou OHI	place (State or For
	Usual Residence of Decedent										-	
on the same	10a. Stata 10b. Cou	nty	100	c. City, Town or L	ocation							10d. Inside City Lin
Me and rot	MARYLAND ANNE	ARUNDEL		GLEN BU	JRNIE							1□Yes 2√
or 28a-fr	10e. Street and Number		-		10f. Zip	Code	1 - 1			10g. Citizen of	What Cou	intry?
urs after death with tr. or flams 23a o traminer mast be by Funeral D	7547 BALEEN  11. Marital Status  1 Never Married 2 N	12. Was D Armed 1 1 Yes	Decedent Ever d Forces? es 2 No , Give or Dates:		21061 Was Decedif Yes, special Yes 2	ify Cub	an, Mexica	n, Puerto	ecify Yes or N Rican, etc.)	UNITE lo- 14. Ra Bia Special	ce - Ameri ick, White	can Indian,
			or Dates.		adaatta tibaa	10				10h Vind of D	lucinos alla	nduoto.
ed within 72 ho ygene. we then "natur it, the Medical Completed	(Specify only hig	lent'a Education hest grade complete	ed)	16a. Deci	edent's Uaua e kind of wor DO NOT us	k done	duning mos	st of work	ing	16b. Kind of B	usiness/ir	adustry
1 E E	Elementary/Secondary (0-12	Cotleg	e (1-4or 5+)		CHOOL !					EDUCA'	TTON	
C Feb		4		50	LIOOL .	LEA						
Aental H read oth fic even	17. Father's Name (First, Midd HERMAN WA	le, Last) LLACE WAL	KER				1		e (First, Middle MOORE	le, Meiden Sumai	me)	
Pull	19a. Informent'a Neme/Relation	onship (Type, Print)		19b. Mai	ling Address	(Stree	t and Numb	er or Run	al Route Num	ber, City or Town	, State, Zi	p Code)
2000	MARYANN WALKE	R/WIFE		7547	7 BALE	EN (	CT. G	LEN I	BURNIE	MD 210	61	
1 1 1 d	20a. Method of Disposition		20	Ob. Place of Diap cemetery, cre	position (Nam	e of			Date	20c. Location	- City or T	own, State
tanti if il fury or	1 Burial 2 Crematic	(Specify)		METRO CI	REMATO	RY		PT.   2000	18	CATONSV	ILLE,	MD
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	21. Signature of Fugiyal Servi	on Ligensee	,		22. Name and				ו דארותו	HOME P.A		
19758	1 ku	I. I ha	ud)							BURNIE,		1061
hysician /Medical xaminer	Immediate Cause (Final disease or condition resulting in death)	ist only one cause to	Non	Smal	LL Ce							Approximate Interval Between Onset and Death
ician and burial-transit al Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury	<b>5</b> b.	Due	to (or es a conse	equence of):					16/19		
ding physise as the	that initiated eventa resulting in death) Last	d	Due	to (or as a conse	equence of):						t	
e attended for us												
by the lached	Part II. Other aignificant cond	itiona contributing to	o death but no	t resulting in the	underlying ca	ause g	iven in Part	i.		d tobacco usa co		to the cause of de obably 4 Unk
been s should leted										as en eutopsy dormed?	8	Vere autopsy findin vaileble prior to ompletion of cause f death?
The law page 2									10	Yea & No	1	☐ Yes 2☐ No
certificate rector, pag	05 Min and of the mark									Mills and the		0.163 20.10
s certific director.	25. Wes case referred to med examiner?	Hospital:				10	26. Plec	e of Deet	h (Check onl)	one)		
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to the roll	27. Manner of Deeth  1 Netural 5 Per 2 Accident inve	ding (N stigation	ete of Injury Jonth, Dey Yea	ar) 28b. Time Injury	of 2	Bc. Inju Wo	uryat ork? ]Yes 2.⊑	]No	28d. Describ	e how injury occu	rred	
To the Hospital or Attending P within 24 hours after death. To the Euronal Director. Alert completely filled in by the funera Medical Certification:	3 ☐ Suicide 6 ☐ Cou	ld not be 28e. Ple	lece of Injury - uitding, etc. (S	At home, farm, soecify)	treet, factory	, office			28f. Location City or T	(Street and Num own, State)	ber or Ru	ral Route Number,
4 hours	29a. Certifier Check only 2 Medic	ying Physician: To	the best of my le basis of exer nenner stated.	r knowledge, dee minetion and/or i	oth occurred a investigation,	at the t	ime, date e opinion, de	nd place, eth occur	and due to th	e cause(s) and me, date and place	anner as , and due	stated. to the cause(s)
within 2 Join Med	29b. Signeture/andrtitle of cert		J. C.unod.		29c	. Licen	ise number			29d. Date sign	ed (Month	, Day, Year)
3 1 3	230. Organistic della con cont			1	200	14	1117	133		and orgin		, , , , , ,
1 10	Iwn	1 Ium	myn			K	17/	1)(		SEPTE	MBER	18, 2000
JAI	30. Name and address of pers	on who completed c	ause of deeth	(item 23e) (Type	Print)							
22 (3	PETER RAMIR	EZ M.D. 7	845 OAT	KWOOD RO	AD GI	EN	BURN	IE. M	ID 2106	1 SUITE	201	
0	31. Date filed (Month, Day, Ye		2. Registrar's S		-							
State		1 8 2000	ha	ended	D A	100	uls					
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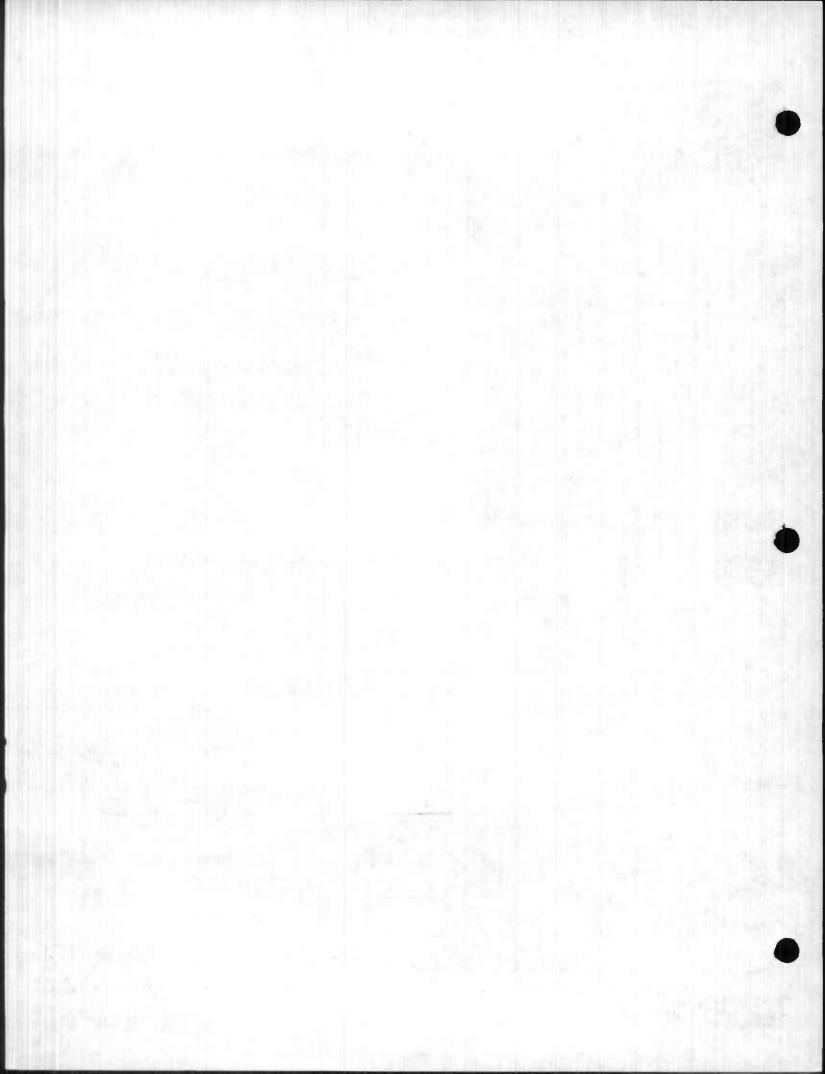


State of Maryland / Department of Health and Mental Hygiene amend item 26 per phys. G787 9/18/00 yf Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 2000 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner -0 en nore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Bir **Funeral** 34-915 10 M 20 F Months Days Hours Min Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Nerns 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director MOY lana 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marifal Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then. Elementary/Secondary (0-12) ge (1-4or 5+) h and Mental Hygier Is marked other th Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Şurname) 8 Pages 1 and 2 should be nent of Health and Mental 19a. informent's Name/Relationship (Type, Print) (Wite 19b. Mailing Address (Street and Namber or Rural Route Number, City or Town, Stete, Zip Code) salto. Mo permit. Pages 1 and 2 Department of Health a Important: If item 27 le any Injury or other tra tone 20b. Place of Disposition (Neme of cemetery, cremetory or other p 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 2000 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service, Licenses 22. Name and Address of Facility Joseph rai Ave 22 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, or heart fallure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medical Immedieta Cause (Final disease or condition resulting in deeth) 201 **Examiner** Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequenca of) I or Attending Physician: The law requires that the death certificate be exafter death.

Director: After this certificate has been signed by the attending physician d in by the funeral director, page 2 should be detached for use as the buria Division of Vital Records. P.O. Box 68760. Due to (or as a consequence of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 10 Yaa 2 No 3 Probably 4 Unknown Be Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 1 □ Yes 2 □ No 25. Was case referred to medica 26. Piece of Deeth (Check only one) Hospitel: 1 Yas 2 5 Presidence Medical Certification: To 1 Inpatient 3 DOA 4 Nursing Home 6 ☐Other (Specify) or of Clean Dete of Injury (Month, Day Year) 28d. Describe how injury occurred injury at Work? 5 Pending investigation 1 Dettatural Injury 1 Yes 2 No 2 Accident 6 ☐ Could not be To the Hospital or Atter within 24 hours after der To the Funeral Director completely filled in by th 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 D Homicide 1.9 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, end due to the ceuse(s) and menner as stated.
2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29e. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number no completed cause of death (Men Ste. 210, Batto, Md. 21228 MID 405 0 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature State 1 8 2000 SEP Registrar

**DHMH 16 Rev 6/95** 

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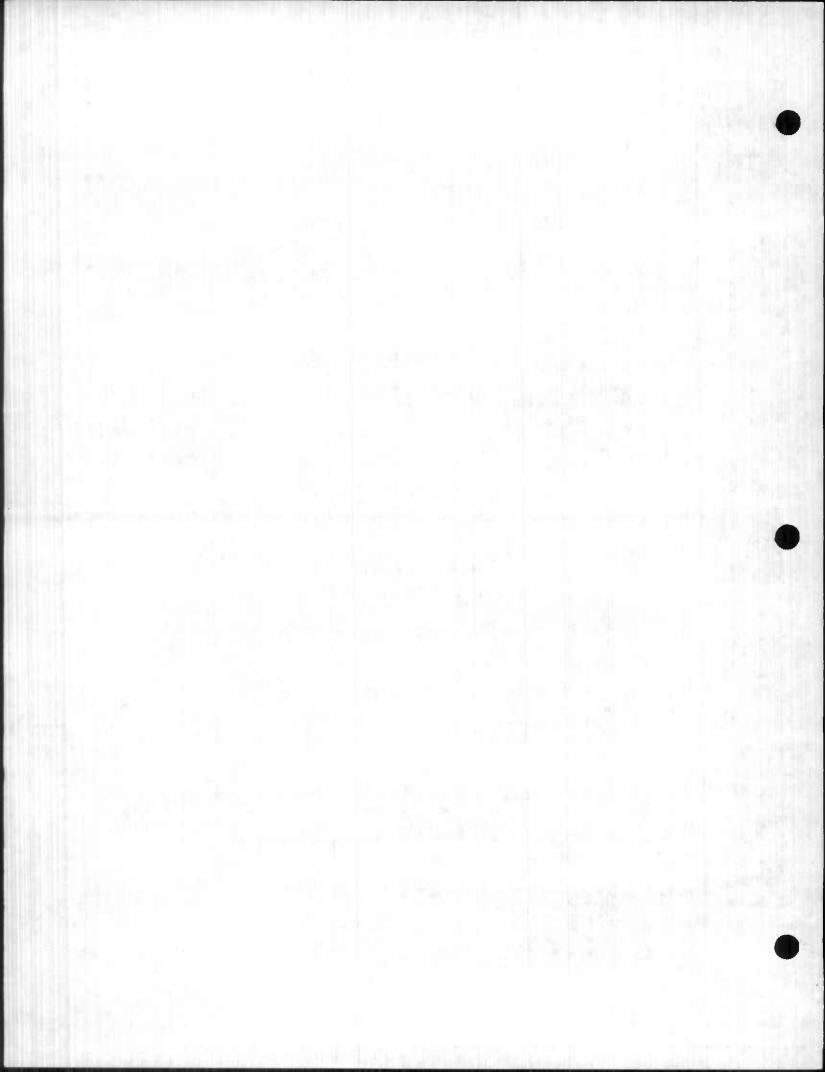


State of Maryland / Department of Health and Mental Hygiene Certificate of Death

•	/Medic Examin
	Funeral Director
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or flams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at other.
•	Physician /Medical Examiner
x 68760,	certificate be executed ding physician and isa as the bunal-transit

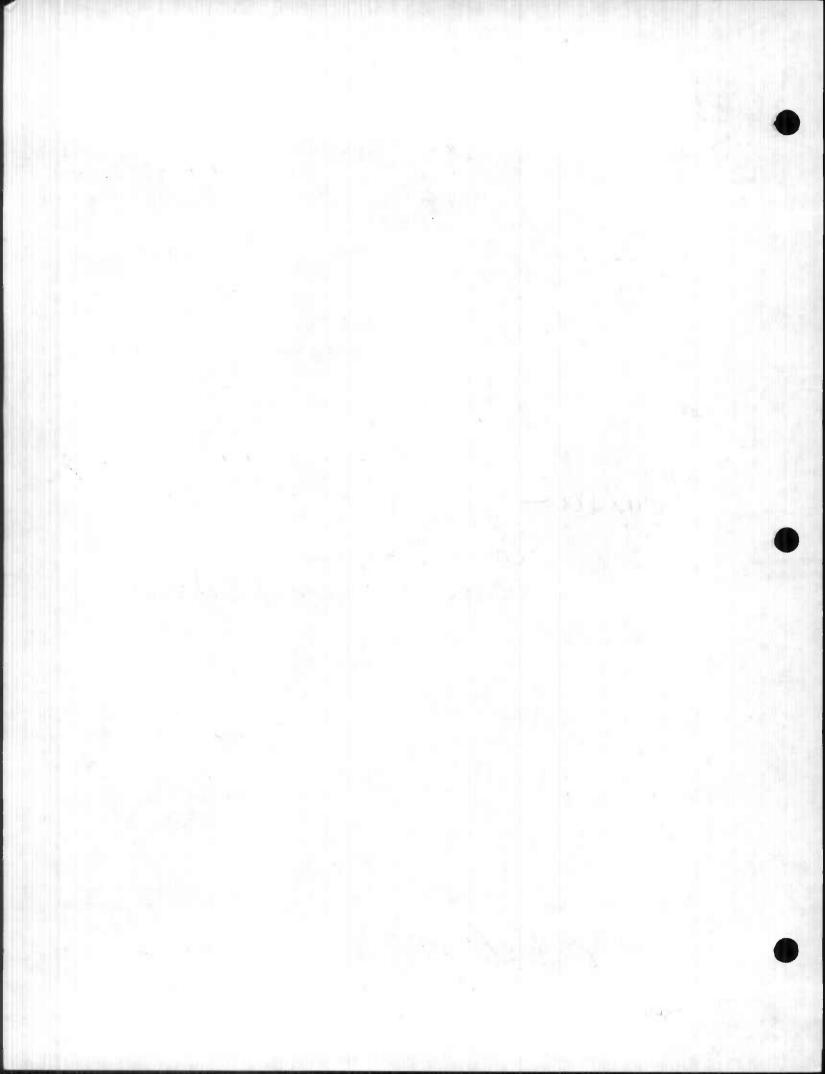
				o o i i i i o a i o	or Dount	rieg. No.	
	Physicia	1. Decedent'a Nama (First, Middle, L	n			2. Date of Death Month Day	3. Time of Death
7	/Medica	FLORA		UILLIAMS		September 11	2000 1157pm
A	Examine		ive street end number)	0 11	4b. City, Town, or I	ocation of Death 4c. Count	y of Deeth
		5. Social Security Number 6.	Sax 7. Age (In yrs	last birthday) If Under 1 Y	aar If Under 24 Hrs.	8. Date of Birth	9 Birthologo (State or Forming
	Funeral Director	14.2-50-4U1U	1 M 2 X F /. Age (III y/s		ays Hours Min.	(Month, Day, Year) JULY 29, 1935	9. Birthplace (State or Foreign Country)  NORTH CAROLIN.
_	Director	Usual Residence of Decedent	$\psi$ ,	9		JULY 21, 190	NORTH CAROLIN
	M M	10a. State 10b. County	10c. C	ity, Town or Location			10d. Insida City Limits
	Mar and and and and and and and and and and	MARYLAND	JIA	BALT	I MORE	CITY	VS 2 No
	or 28s	MARYLAND  10e. Street and Number		10f. Zip Cod		10g. Citizen of	What Country?
			ID PARK D	RIVE	2121	1 4	5A.
	ems ems	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Evar in t Armed Forcas?	J.S. 13. Was Decedent If Yas, specify (	of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yas or No- o Rican, etc.) 14. Ra	ca - American Indian, ack, Whita, etc.
20	a a m		1 ☐ Yas 2 🔼 No If Yes, Give	1□Yas 2⊠		Speci	
5-0020		3 N Widowed 4 □ Divorced	Year or Dates:				BLACK
5	nath edica	15. Decedent's E (Specify only highast g Elementary/Secondery (0-12)	Education reda completad)	16a. Decedent's Usual Oc (Give kind of work do	ocupati <i>on</i> ona <i>duri</i> ng most of wor otired)	king 16b. Kind of 8	Business/Industry
12	William Salah	Elementary/Secondery (0-12)	College (1-4or 5+)	^			E TI AT PAUTILIA
9	Hard Hard	17. Father's Name (First, Middle, Las	IVR	DOMESTI		ne (First, Middle, Meiden Sume	STY OF BALTIKUR
an	the part of the pa	10		ETT	F117	A TANK	1 FF
7	M M M	PROSEVELT  19a. Informant's Name/Relationship		1	reet and Number or Ru	ural Route Number, City or Town	n. State. Zip Code)
Ř	12 mm	SHAPPALLITAN	ED (DNICHTE)	3961 A An	III PARK	h to	ORE, NO. 21211
é	- Tage	20a. Mathod of Disposition	20b.	Placa of Disposition (Neme of	DIDIANE		- City of Town, State
OL	A or	1 Burlal 2 Cremation 3 4 Donation 5 Other (Spec	_Hemoval from State	cemetery, crematory or other		9-11-M BA. T	HARLE HARMIN
₫	in land	21. Signature of Funeral Service-Lice		22. Name and A	DETERY!	1-10 WINALI	MORE, MARYLAN
ñ	E CONTROL	1 XXII		JOSEF	PH H. BR	DWN JK. PUN	ERAL HOME
				th. Do not enter the mode of	V. FULTON	AVE, BALT	THORE, MD 2/21
ŶĮ,	D1	23a Part1. Enter the disease, or con shock, or heart failure. List only	y one cause on each line.	in. Do not enter the mode of	dynig, such as cardiac	or respiratory arrest,	Interval Between Onsat and Daath
	Physician /Medical	Immediata Cause (Final	1.1.	M	OI T	(1.	1
	Examiner	disaase or condition resulting in death)	a. 176070	ryocar	0421 +	ntarction	
		5	Due to (	or as a consequence ot):			
	exacuted an and hal-transit	Samuelially list and ities	b	or as a consequenca of):	m)2.		
ć	physician and s the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or thjury	04010	or as a consequence ory.			1
68760	ficate be physicia is the bur	Cause (Disease or trijury that initiated events	c. Due to (	or as a consequence of):			
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m .	ires that the death signed by the atter d be detached for u	Part II. Other eignificant conditions	contributing to death but not re	sulting In the underlying cause	e given in Pert I.	23b. Did tobacco use c	ontribute to the cause of death?
0.	requires that the					1 ☐ Yes 2 ☐ No	3 Probably 4 ☐ Unknown
Ś	on de						
Record	been si should					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to
000	law re las be 3 2 sho						completion of causa of death?
	The law					1 ☐ Yes 2 🗷 No	1 ☐ Yes 2 ☐ No
<u>e</u>		25. Was case referred to medical			26. Plece of Dec	eth (Check only one)	
of Vital	dire dire	examiner?	Hospital: 1 Inpatient 2	SER/Outpatient 3□ DOA	Other: 4 Nursing H	fome 5 ☐ Residence 6 ☐ O	thar (Specify)
0	ding Phi After thi funeral		28a. Dete of Injury (Month, Dey Year)	28b. Time of 28c.	Injury et Work?	28d. Describe how injury occu	ırred
Division	Attanding or death. sector: Afte by the func	1 Naturat 5 Pending investigation	on		1 ☐ Yes 2 ☐ No		
<u>&gt;</u>	after deat Director: In by the	3 Suicide 6 Could not determine	28e. Placa of Injury - At I building, etc. (Spec	nome, farm, street, factory, of	fica	28f. Location (Street and Nurr City or Town, Stete)	nber or Rural Route Number,
۵	ital or Atlanding Pirs after death.  al Director: After t led in by the funer.						
	thou uner	29a. Cartifier 12 Certifying P	hyeician: To the best of my kn	owledge, death occurred et the	ne time, dete end plece my opinion, death occu	a, and due to the cause(s) and nurred at the time, date end plece	nanner as stated.
			and manner stated.				
	T V TO	29b. Signature applifile of certifier	1 1 10		canse number		ed (Month, Day, Year)
	1	Dantend	20-1- 11.	- 11 - D	2171-	Septe	wher 11.2000

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) W. Belvedere, Betto, MD 21215 Franklin, MD Broderick
31. Date filed (Month, Day, Year) State SEP 1 8 2000 Registrar



State of Maryland / Department of Health and Mental Hygiene

ian	1. Decedent's Name (First	Middle Le													
ian		mioura, La	S()							2. Data of D				3. Tim	e of Death
1011	Pohort Uc	bacas	winder.	-14 T.	M D					Month	Day		Year	10	.OO TM
ical	Robert Ho				., M.D.			th City To	wn orlo	SEPTEM		the same of the sa	2000   of Death	10	:09 PM
ner							100			roution or oou					
	SAINT JOSEP			7		T Millada		TOWSC				BALT	IMORE		
	5. Social Security Number 6. S		Flat of F			Months Da			Min.	8. Data of Bir (Month, Da 09/2	rth ay, Year) 25/1957		Birthplece (State or Foreign Country)     Maryland		
	212-60-1426				42 Yrs.										
	Usual Residence of Deceded 10a, Stata 10b.			100	City Town and a	tion							110	of Sector	Oh dhah
		County		106.1	City, Town or Lo	ocation							10		e City Limits
1	MD B	MD Baltimore Phoenix								1 L Ye				res 212/No	
ĺ	10e. Street and Number					10f. Zip Code					10g. Citizen of What Country?				Thy Tee
	2807 Stockton Road 21131							tIn:				nited States			
11. Marital Status			12. Was Dacedent Evar in U,S. 13. Was D				recedant of Hispanic Origin? (Specif specify Cuben, Mexican, Puerto Ric			ecify Yes or N	-	- 14. Race - Amarican India		n Indiar	١,
1 Never Married 2 Married		1 ☐ Yes 2√3No						Rican, etc.)		Bleck, White, etc.					
3 ☐ Widowed 4 ☐ Divorced			If Yes, G	iva		1 🗆 Yes	2 XNo	No Specify:			Specify: WHite				
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	(Specify only	highast gri	ada completed	3)	16a. Decedent's Usual Occup (Give kind of work dona of life, DO NOT use retired			a duning most of working			16b. Kind of Business/Industry				
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Ì	17 Fathers Many 1891	Airdell - A		5 +		Family Pract					Malda	Medica Sumama		11	
1	17. Father's Neme (First,							18. Mother's Name		, Maiden	warden Sumame)				
	Robert Ho	ward	Wiedelf	feld, S	r.			Ma	arie	Dorse	У				
	19e. Informant's Name/Re	tetionship (	Type, Print)		19b. Malli	ing Addres	s (Street	and Number	er or Run	al Route Num	ber, City o	r Town,	State, Zip (	Code)	
	Mrs. Susann	e M.	Wiedefe	eld/wif	e 2807	Stoc	ckton	Road	a I	hoenix	, Mai	ryla	nd 21	131	
l	20a. Method of Disposition			20b	. Place of Dispo	osition (Na	me of			Date	20c. Lo	cation -	City or Tov	vn, State	9
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	4 □ Donation 5 □ C	nei (Specii	y)	PE	. Louis	Chur	CII C	,eme ce	TYV	7/ 10/ 00	Clai	LKSV	TITE,	MD	
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### Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Anna Day Year Vainberg 0035 September 14 2000 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death North west Randallstown Hosp. Center Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) Deys Min. Months Hours 1 ☐ M 2 💢 F Yrs. 94 JUL.29,1906 UKRAINE 215-90-7788 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No MD BALTIMORE RE:ISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21136 UKRAINE 12511 FELLOWSHIP COURT 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11. Meritel Status Bieck, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 No Specify: Specify: WHITE 3 □ Widowed 4 □ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) **PINCUS** SHUMYATSKY GITTEL (UNKNOWN) 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) IRENA CULOTTA / GRANDDAUGHTER 12511 FELLOWSHIP COURT - REISTERSTOWN, MD 21136 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) BALTIMORE HEBREW CEMETERY 9/15/00 REISTERSTOWN, MD 21. Signeture of Funerei Service Licensee 22. Name and Address of Facility SCL LEVINSON & BROS., INC. Johns 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) 1 month Metastatre non small cell lung Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lasf Due to (or as a consequence of): Due to (or es e consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were sutopsy findings available prior to completion of cause of death? 24e. Wes en autopsy performed? 1 Yes 2 No t ☐ Yas 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred

Physician /Medical Examiner

Department of Important: If any injury or other

**Physician** 

/Medical

Examiner

Directo

Funeral

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Completed

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**Funeral** 

Director

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"natural"

Hygiene.

. Pages 1 and 2 should be the travers of Health and Mental H fant: If hern 27 is marked oth dury or other traumatic even

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filed within 72 hours after

21215-0020

Baltimore, Maryland

pue physiclan the US0 85 1 After this certificate has funeral

Examiner The law requires that the death certificate be executed Box 68760. Physician/Medical Division of Vital Records, P.O. þ Medical Certification: To Be Completed or Attending Physician: Hospital or Attending
 24 hours after death.
 Funeral Director: Aft filled in by

compietaly

within 2 \$

> State Registrar

1 Netural

2 Accident

3 Suicide

29e. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

29c. License number D 32844

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) September 14

2000

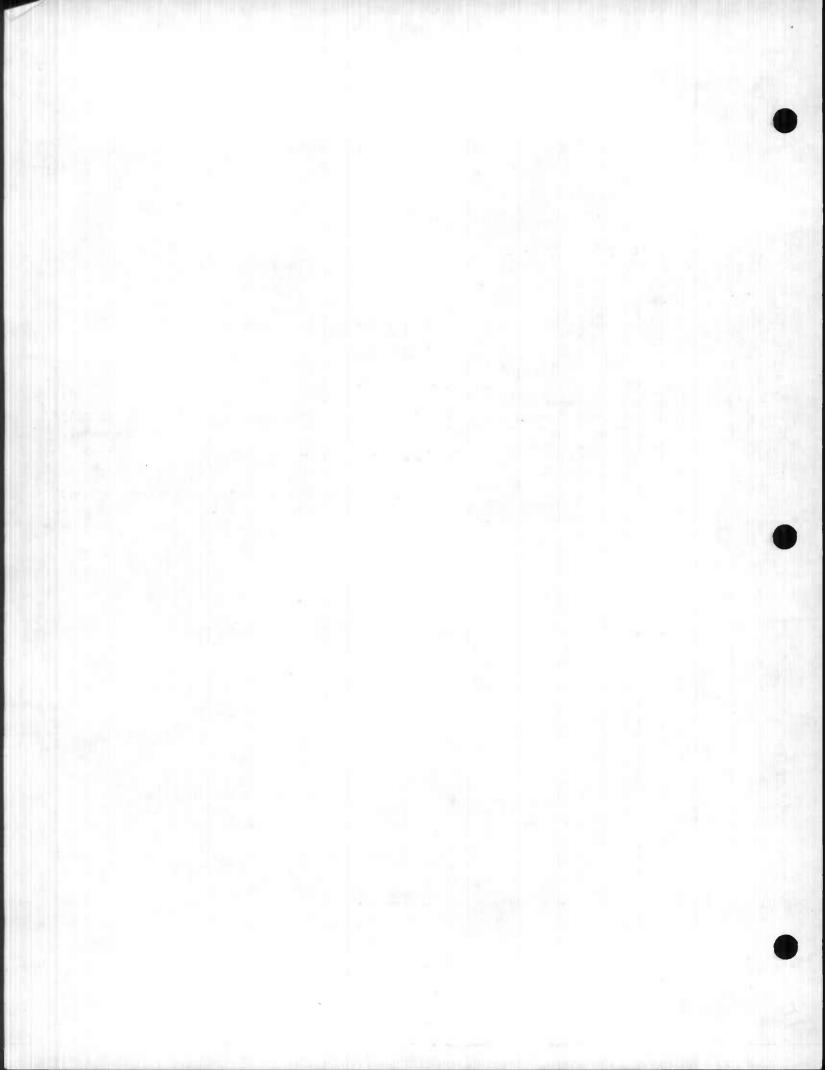
281. Location (Street and Number or Rural Route Number, City or Town, Stete)

21136

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)
DRoggen 5401 Old Ct Rd Randalls town

28e. Pieca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

32. Registrer's Signeture Darks

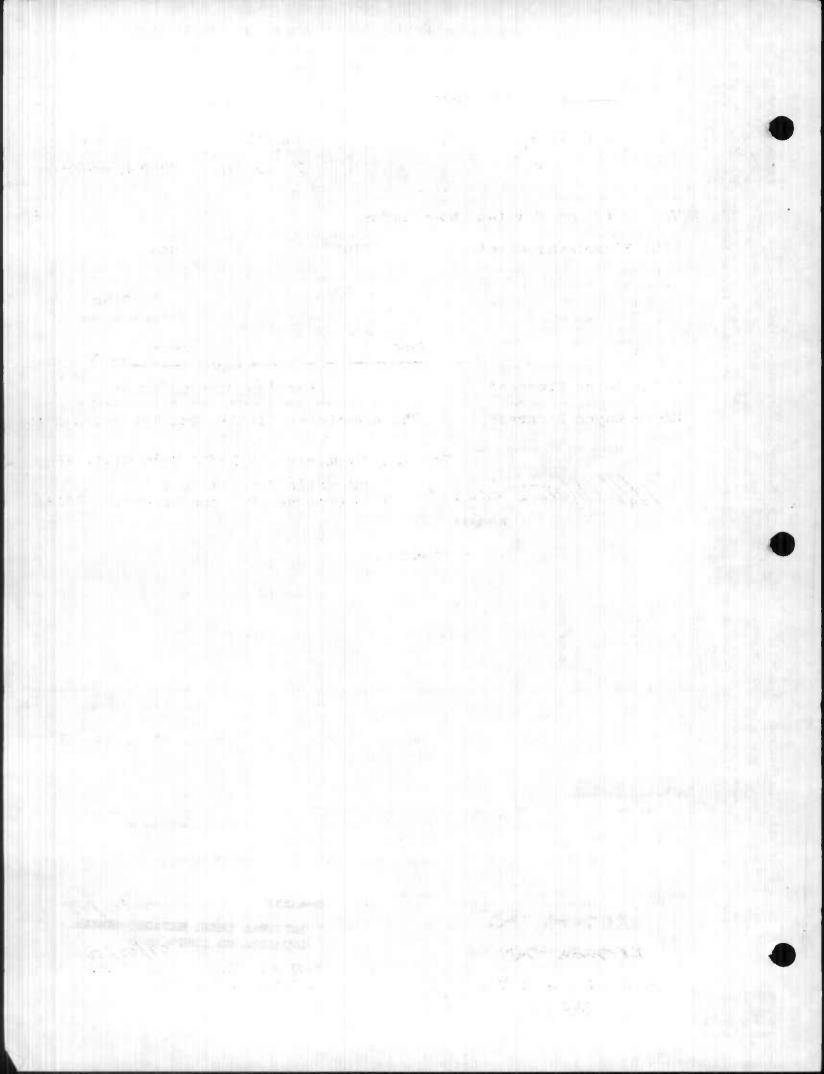


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Amended Item#1 perPhyG788 10/12/2000 EW State of Maryland / Department of Health and Mental Hygiene amend item 5 per fh G787 9/18/00 yf Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **JAXXSON Physician** ST.JOHN ARMSTEAD SEP 6 2000 6:58 PM /Medical Jaxxon 4b. City. Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 24 Hrs. 8. Date of Birth (Month, Day, Yaar) Sep 6, 2000 H Under 1 Year 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** Days Months n/a 15 M 2 F 0 Vre Montgomery Director Usual Residenca of Decedant the Maryland 10c. City, Town or Location t0d. Inside City Limits worle ! r than "natural", or items 23a or 28a-f ehov the Medical Examinar must be notified at 1 Yes 2 No Director Prince William Woodbridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1351 Eisenhower Circle 22191 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Never Married 2 Married 1 ☐ Yes ② No If Yes, Give 1 Yes ZANo Specify: Specify: Black altimore, Maryland 21215-0020 2 3 ☐ Widowed 4 ☐ Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Spacify only highast grada completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elamentary/Secondary (0-12) Collage (1-4or 5+) None None 0 permit. Pages 1 and 2 should be file.
Depertment of Health and Mental Hy, important: if item Z7 is marked othe any injury or other traument. 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Surnama) Be Eddie Wayne Armstead Carolyn Denise Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routs Number, City or Town, Stats, Zip Cods) Eddie Wayne Armstead 1351 Eisenhower Circle, Woodbridge, VA 22191 20b. Placa of Disposition (Nama of 20c. Location - City or Town, State 20a. Method of Disposition Date cematary, crematory or other place) 1 ☐ Burial ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Potomac Crematory 9/13/00 Dale City, VA 22. Name and Address of Facility Mountcastle Funeral Home CC0387 13318 Occoquan Rd. Woodbridge, VA 22191 23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final EXTREME PREMATURITY disease or condition resulting in death) Examiner Dua to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediata cause. Enter Underlying Cause (Diseasa or Injury that initiated avants resulting in death) Last pue burial-trar Due to (or as a consequenca of): physician Physician/Medical the Due to (or as a consequenca of): as ŏ deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? o the been signed by t should be detect 1 Yas 2 No 3 Probably 4 Unknown Records, by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital director, Be 25. Was casa raferred to medical examiner? 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA his 28a. Data of Injury (Month, Day Year) uneral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 5 Pending investigation 1 Natural 2 Accidant 1 ☐ Yes 2 ☐ No death. or Attended of the deat 6 Could not be datermined 3 Sulcide 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida To the Hospital within 24 hours e To the Funeral C Hospital 24 hours e 29a. Cartifiar 🖔 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to the causa(s) and mannar as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month. Dav. Year) D-41551 Remons 09/07 100 30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER R.R.MOORES, LTC/MC/USA BETHESDA MD 20889-5600 31. Date filed (Month, Day, Yaar) 32. Registrar's Signature

2000

oaks

Registrar



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	Physicia /Medic	al		rothy Ge	rtrude		rd			Ab City Town	2. Date of Month Seg., or Location of Do	ot. 3		Year	ima of Death
	Examina Funeral Director	er	5. Social Security Numb 219-03-0982	emorial 6. Sex	Hosp		lest birthde	Mont	nder 1 Yea hs Deys	East	ton Hrs. 8. Date of	Birth Day, Year	Talb	ot	State or Foreign
	the Maryland r 28e-f show notified at	Director		c. County			ty. Town or enton		Zip Code			10g. C	itizen of W		side City Limits  Yes 222 No
020	ars after death with	by Funeral Di	9782 Foy R 11. Marital Stetus 1 Never Married 3 Widowed 4	2 Married	12. Was Deced Armed Forc 1  Yes 2 If Yes, Give Year or Dat	es?	J,S. 1	3. Was De If Yes,	21629 ecedent of specify Cu	Hispanic Origin ban, Mexicen, F	? (Specify Yes or Puerto Rican, etc.)		14. Race Black Specify:	States - American Inc. k, White, etc	lian,
Dorothy d 21215-0020	d within 72 hou gions. ir than "nature the Medical E	Completed	15.	Decedent's Educ nly highest grade	cetion completed) College (1-4	lor 5+)	(G.	ive kind of a. DO NO		upation e during most of ed)		Clo	Kind of Bu	siness/Industry	Poultry
- E	should be file and Mental Hy, marked othe umsitic event,	To Be C	17. Father's Name (Firs  Ben 19a. Informant's Neme/	jamin Fr		Brown		ailing Add	ress (Stree	C	Name (First, Mid Lara Town or Rural Route Nu	msend	d Wya	tt	)
Baynard timore, Maryla	C TO DE LA		John Frank  20a. Method of Disposit  1 🗷 Buriel 2 🗆 Cr  4 🗆 Donation 5 🗆	ion remetion 3 □R ]Other (Specify)	emoval from St	20b. I	863 Place of Discemetery, o	sposition ( crematory	Neme of or other pi etery	ace)	Date 9/8/00	20c. I	Location -	Maryla City or Town, S Maryla	tate
Ba	Physician		21. Signature of Funera  23a. Part f. Enter the di shock, or heert fai	ofur	cations that car	used the deal	th. Do not	Moor	re Fu	neral H	Iome, P.A. Street, ordiec or respireto	Den	ton,	Appr	oximate vat Between et and Deeth
	/Medical Examiner	ulner	Immediate Cause (Fina disease or condition resulting in death)	at a	1	PRT	or as a con	sequence URE	of):					1 4	IEER
Box 68760.	Da Sign	n/Medicai Examiner	Sequentially list condition of the cause. Enter Underlyin Cause (Disease or Injurthat initiated events resulting in death) Last	ons, diate g y	Mit	RAL	VAL	VE	Dus	FUNC	-710N				
0.	hat the o	by Physician/Medic	Part II. Other significan	t conditions con	tributing to dea	th but not res	sulting In th	e underlyii	ng ceuse (	given in Part f.				atributs to the	causs of death?
Division of Vital Records.	The law requires that are has been signed b page 2 should be deto	Completed b							H		F	Vas an aut erformed?		available complet of death	itopsy findings e prior to ion of cause ?
Vital	Physician: The this certificate ral director, pag	o Be	25. Was case referred taxaminer?	-	lospital:	patient 2	] ER/Outpa	tient 3	DOA	Wher:	f Death (Check o		6 □Oth	er (Specify)	
vision of	Attending Physic death.  Sctor: After this by the funeral di	Certification: T	27. Menner of Death  1 Naturat 5 2 Accident	Panding investigation Could not be determined	28a. Date of (Month) 28e. Place of	Injury , Day Year) of Injury - At h	28b. Tim Injui	a of y M	28c. In W	ury at ork? ☐ Yes 2 ☐ No	28d. Description 28f. Location	ibe how in	jury occum		te Number,
Q	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical Cert	29e. Certifier 12 (Check only 2	Certifying Phys	ifclan: To the b	is of examina	owledge, de				place, and due to occurred et the ti	the cause	(s) and ma		cause(s)
•	To the within 2 To the comple	Med	29b. Signature and title	of certifier	and menne	or Stated.				nse number	5	29d. D	1 ,	d (Month, Day,	Year)

State Registrar DHMH 16 Rev 6/95

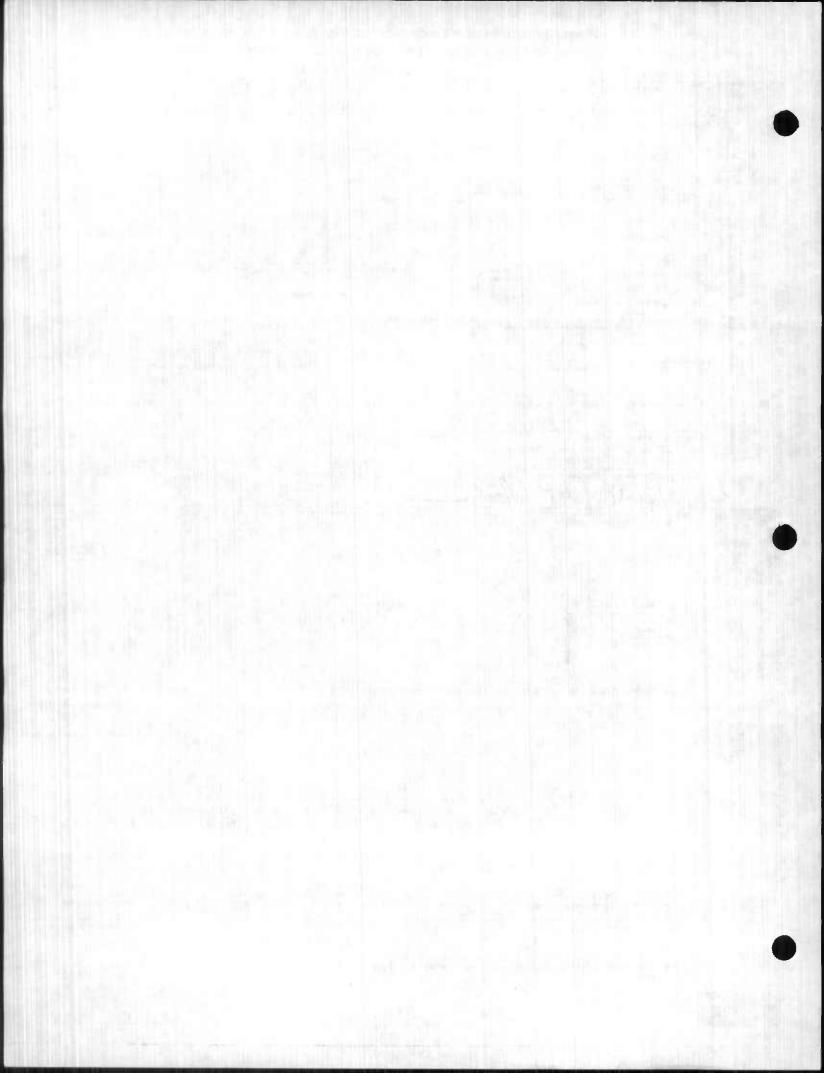
Korah Pulimood, M.D., 510 South Fifth Avenue, Denton, Maryland 21629

31. Date filed (Month, Day, Year)

SFP - 5 2000

32. Registrar's Signature

G. Sparks



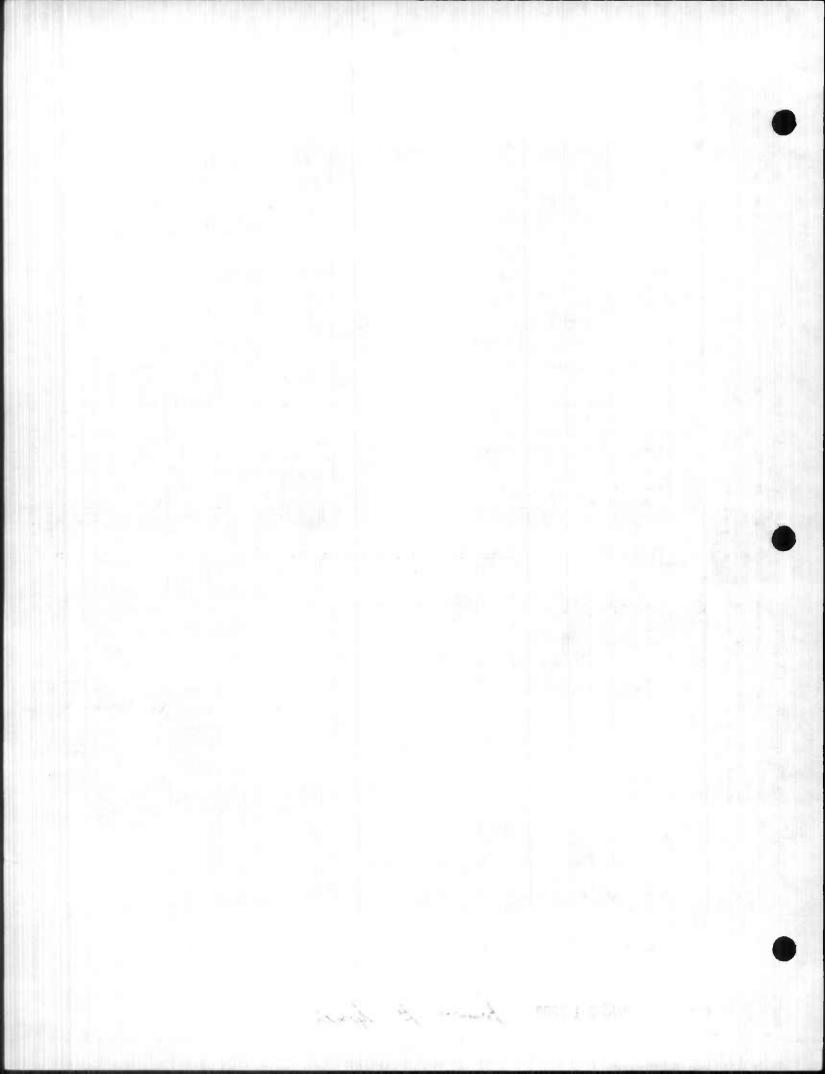
### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Month Year Physician FAWN BARADA BRITT AUGUST 30 2000 1:00 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner OLD CASH VALLEY ROAD AVALE If Under 24 Hrs. H I Inder 8. Date of Birth Month, Pay. JULY 19 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Hours Months Davs 10 M 25 F MARYLAND 215-26-6525 81 Director **Usual Residence of Decedent** the Manfand 10c. City, Town or Location 10a State 10b. County show 10d, Inside City Limits items 23e or 28e-f show ther must be notified at ALLEGANY 1 Yes 2 No MARYLAND LAVALE Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? fig. 7 OLD CASH VALLEY ROAD 21502 U.S.A. Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien. Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: filed within 72 hours after thygiene. Obserthen "natural", or its 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Importants if hem 27 is marked other the any injury or other traumatic HOME MAKER HOME MAKER 17 Father's Name /First Middle ( ast) 18 Mother's Name (First Middle Maiden Sumeme) 89 EARL STURTZ BESSIE LAW 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) OTIS W. BRITT HUSBAND 7 OLD CASH VALLEY ROAD LAVALE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ZION MEMORIAL PARK SEPTEMBER 2 2000 CUMBERLAND MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) atum of Funeral Service Lin 22. Name end Address of Facility MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Intractable congestive heart failure 1 year Examiner Due to (or as a consequence of): Examiner physicien and the burial-transit The law requires that the death certificate be executed Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or es a consequence of): for use as 000 signed by the e P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 s hee 2 0 No 1 Yes 1 Yes 2 No Division of Vital Attending Physician: 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation 1 MNatural To the Hospital or Attending within 24 hours attar death. To the Funeral Director: Atta completely filled in by the fundaments of the fundaments. 1 □ Yes 2 □ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. edical 29a. Certifie 29b. Signative and title of cer 29c. License number 29d. Dete signed (Month, Day, Year) as D 16041 AUGUST 31, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 DR TERRY WILLIAMS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND MARYLAND AUG 3 1 32. Registrar's Signature 2000 Registra

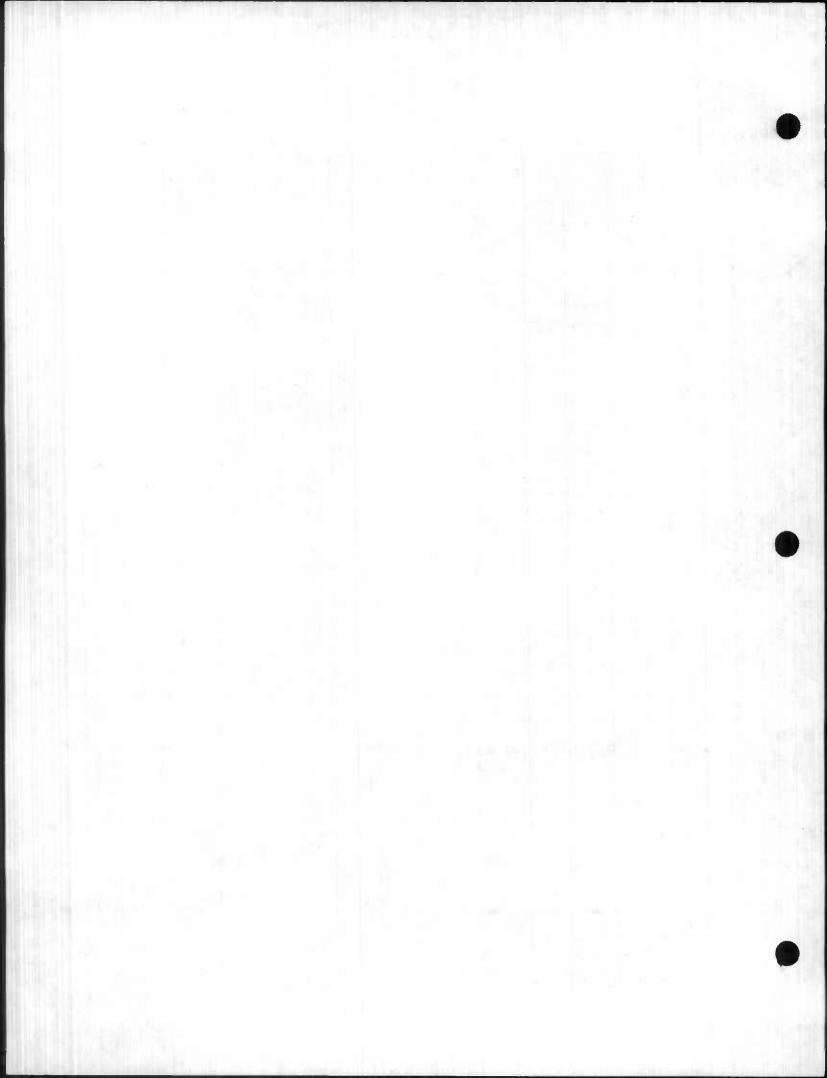
DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 00 29381

		Certificate of Death	Reg. No.	4000
Physician (Madical	1. Decedent's Name (First, Middle, Last)  MARIE LILLIAN CHIASSON		2. Date of Death Month Day Y September 6 200	3. Time of Death ear 7:50PM
/Medical Examiner	ta Facility Name (If not institution, give street and number) Civista Medical Center	4b. City, Town, or LaPlata	ocation of Death 4c. County of Charle	Death
uneral irector	5. Social Security Number  148-34-7787  6. Sex 1	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) APRIL 3, 1924	Birthplaca (State or Foreig Country) CANADA
notified at	10a. State 10b. County 10c. City, Town of NEW JERSEY MIDDLESEX SOUTH		XIII. SELECTION IN CONTRACTOR OF THE CONTRACTOR	10d. Inside City Limits 1 ☐ Yes 2 💢 No
0 8	10e: Street and Number 253 9TH STREET	10f. Zip Code 08879	10g. Citizen of What	at Country?
Examiner must	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U,S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S if Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)  14. Race - Black,  Specify: V	American Indian, White, etc.
Completed	(Specify only highest grade completed) (C	ecedent's Usual Occupation Give kind of work done during most of wor fe. DO NOT use retired)	king 16b. Kind of Bush	ness/Industry
Be Com	Elementery/Secondery (0-12)  10  17. Father's Name (First, Middle, Last)	HOME MAKER  18. Mother's Nam	OWN HO	ME
ToB	HIBERT FOSTER	UNAVAIL		Tio Codel
		Mailing Address (Street and Number or Ru  HUNTINGTON CIRCLE		
	20a. Method of Disposition  1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify)	isposition (Neme of cremetory or other place) . CREMATORY	Date 20c. Location - Cit 9/11/2000 LINDEN	
JP	21. Signature of Funeral Sarvice Licensee  JOHN P. KNISLEY M01164	22. Name end Address of Facility THE HUNTT FUNERAL 156, WALDORF, MARY		
lan/Medical Examiner	Due to (or as a constitution of the conditions, and the conditions, and the conditions, and the conditions of the conditions, and the conditions of the cond	nsequence of): SE 015010E1	LAAY OISEASE	
by Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the SEUERE OSTEOPOROSIS	ne underlying cause given in Part I.	23b. Did tobacco use contr 1  Yes 2 □ No 3	ibute to the cause of dea
pleted by	MULTIPLE COMPRESSION	FRACTURES	24a. Was en eutopsy performed?	24b. Were autopsy finding: available prior to completion of cause of death?
Com			1□ Yes 2 No	1□Yes 2ENo
o Be	25. Was case referred to medical examiner?  1 🗆 Yes 2 🖾 No Hospitel: 1 🖼 npatient 2 🗆 ER/Outp.	Other	ath (Check only one)  forme 5 ☐ Residence 8 ☐ Other	(Specify)
edical Certification: To Be Completed by Physiclan	27. Manner of Death  1 Netural 5 Pending Investigation  3 Suicide 4 Homicide 28e. Place of Injury (Month, Dey Year) 28b. Time (Month, Dey Year	ne of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how injury occurred 28t. Location (Street and Number City or Town, State)	
completely filled in by the funeral director, page  Medical Certification: To Be Com	29a. Certifier (Check only  1 Certifying Physician: To the best of my knowledge, d  2 Medical Examiner: On the basis of examination and/c	leeth occurred et the time, date and place	e, end due to the cause(s) and mann	
completely filled Medical Co	29b. Signature and title of cartifier  Rubaid & B	29c. License number D - 48119	29d. Date signed (	Month, Day, Year)
	Richard E. Bransdorf, M.D.	<sup>/pe, Print)</sup> 12070 Old Lin Waldorf,Maryla	e Center Suite 1 nd 20602	000
State Registrar	31. Date filed (Month, Day Year) 0 7 2000 32. Registrar's Signature	B. Spark		



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2000 Month Aug 30, 11:25pm Wanda Clugston Pressman 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death | Cumber 1 | Cumber 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | Min. | Mar 31, 19 Cumberland Nursing Home Allegany 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 1□ M 2□ F Yrs. 95 1905 214-07-1109 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits Yes 2□No Allegany Cumberland 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 135 N. Mechanic Street #608 21502 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 【 No If Yas, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. X Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specifyhite 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Switchboard Operator Algonquin Hotel 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Elizabeth (Pressman) William C. Clugston 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. informant's Name/Relationship (Type, Print) \$andy Asher Route 1 Box 28J; Wiley Ford, WV 26767 Collection of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) German Beneficial Ceme9/02/ Cumberland, MD 21 Signature of Funeral Service Licenses Scarpelli Funeral Home P.A. Cumberland, Maryland 23a. Part / Enter the disease, or complications that baused the death. Do not entar the mode of dying, such as cardiac or reapiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ande disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

**Physician** /Medical **Examiner** 

**Physician** 

· /Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23s or 26s-f show the Medical Example: must be notified at

Directo MD

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Completed

Be

12

the Marylen

death with

Baltimore, Maryland 21215-0020

Box 68760 certificate be

Records, P.O.

Division of Vital

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mentel Hygiene. Important: If fem 27 is marked other than "na any injury or other traumatic avantage."

burial-trans pue physiclen the 88 980 Por signed by the a peen page 2 certificate or Attending Physician: effer death. Director: After this certific funeral director,

Certification: To

Examiner Physician/Medical p Completed Be

25. Was case referred to medical exeminer?

1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident

6 Could not be 3 Suicide 4 Homicida

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 5 Pending Investigation

28b. Time of

1 ☐ Yes 2 ☐ No 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred

1 ☐ Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29b. Signature and title of chilling 10 29c. License number 066 33 280 29d. Date signed (Month, Dey, Year) August 31 2000

1 ☐ Yea 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Typa, Print)

Dr. Sunil K. Gupta, M.D., 625 Kent Avenue; Cumberland, MD 21502 31. Date filed (Month, Dey, Year) 32. Registrar's Signeture

State Registrar

Ry

Medical

29a. Certifier

(Check only one)

SEP 0 1 2000

• Funeral Hospital

within 2 To the

0-2EP 0 1 7006 Journal

### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

		State of	Marylan		artment of F		and Mer		giene Rog. No. () (	) 2	9383
Physician (Madical	Decedent's Name (First, Middle,     Mildred Cheshi:			41				Date of Dea Month	Day	Year 00	3. Time of Death
/Medical Examiner	4a Facility Name (If not institution, ) Cumberland Nursi		per)	913			wn, or Locati	on of Death			
Funeral Director	5. Social Security Number 213-48-1229	Sex 7.	Age (In yrs. 93	last birthday, Yrs.	If Under 1 Yeer   Months   Days	If Under	Min.	(Month, Day	r, Year)	Coun	try)
effer deeth with the Meryland or thems 23e or 28e-f show inforcement be notified at Funeral Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Alleg	any		, Town or L						10	0d. Inside City Limits  2 Yes 2 No
th with the Me 23a or 28a-fe at be notified	10e. Street and Number 313 Hammond St				10f. Zip Code 21562		Jan 6, 1907   Maryland				
of the start of th		Armed Force 1 1 Yes 2 If Yes, Give	es? No	S. 13.	If Yes, specify Cub	an, Mexican	gin? (Specify , Puerto Rica	Yes or No- an, etc.)	Blac	k, White,	etc.
Aaryland 21215-0020 2 should be filed within 72 hours effer and Mental Hygiens. Is marked other than *natural*, or tha raumatic event, the Medical Examina To Be Completed by Fu	313 Hammond St.  1. Marital Status 1. Marital St										
Maryland d 2 should be file th end Mental Hy 7 is marked other traumatic event.	17. Father's Name (First, Middle, La	st)							_	18)	
Mary and 2 sho slih end N 27 is me or traume	19a. Informant's Name/Relationship	-				tt  Zip Code  Zi					
Baitimore, Maryland 212: permit. Pages 1 end 2 should be filed within Department of Health end Mental Hygiena. Important: If flem 27 is marked other than any injury or other traumetic event, tha Hands.  To Be Compi			ete o	emetery, cre	matory or other ple						
Ball permit Depart import any in			l	В	oal Funeral	Home		nnort	MD 2156	32	
Physician /Medical	shock, or heart failure. List on	mplications that cau ly one cause on eac	h line.	n. Do not en	ter the mode of dyi	ng, such as	cardiac or re	spiratory an	rest,		Interval Between Onset end Deeth
Examiner	resulting in death)	8.	Due to (o	as a conse	quence of):	5Wi C	vc	Ė		1 1	Vec. 15
P.O. Box 68760, set the death certificate be associed by the attending physician and etsched for use as the buriel-transit. Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last	c									years
by P.O. Box 6. the the death certification of by the attending profession for use as y Physician/Mex	Part II. Other significant conditions	contributing to deat	h but not resu	alting in the u	underlying cause given	ven in Pert I.		23b. Did to	obacco usa co	ntribute to	the cause of death?
		CVA Tehydro						101	res 2X No	3 ☐ Prot	bebly 4 Unknown
av requir se been s 2 should pleted	1	Tehydre	ation							alva	allable prior to repletion of cause
- F & a O	25. Was case referred to medical examiner?						of Death (C			10	Yes 2 No
Vision of Attending Phys of deeth. ector: Attacthis by the funeral diffication: To	1 Yes 2 No  27. Manner of Death 1 No Natural 5 Pending investigat 3 Suicide 6 Could not determine	28a. Data of (Month,		28b. Time of thijury	28c. Inju	4 KI NU	No 28d	. Describe h	ow injury occur	red	r) Il Route Number,
Dispense or no 24 hours after the Functed Dispense of the pleistery filled in edical Cert	(Check only 2   Medical Ex	Physician: To the be	est of my know	vledge, deat	th occurred at the time	me, date an	d place, and	due to the d	cause(s) and ma	anner as st	ated.
To the Hospital within 24 hours a To the Funaral D completely filled	29b. Signature and title of certifier	and manner	r stated.		29c. Licens	se number			29d. Dete signe	d (Month,	
62		o Completed ceuse of	of death (Item	239) (Type,	st. Cu	mber	land	, Na	(2150	2	
State Registrar	31. Date filed (Month, Day, Year)  AUG 3 1		strar's Signal	lure E	1 Spor	Es .					

DHMH 16 Rev 6/95

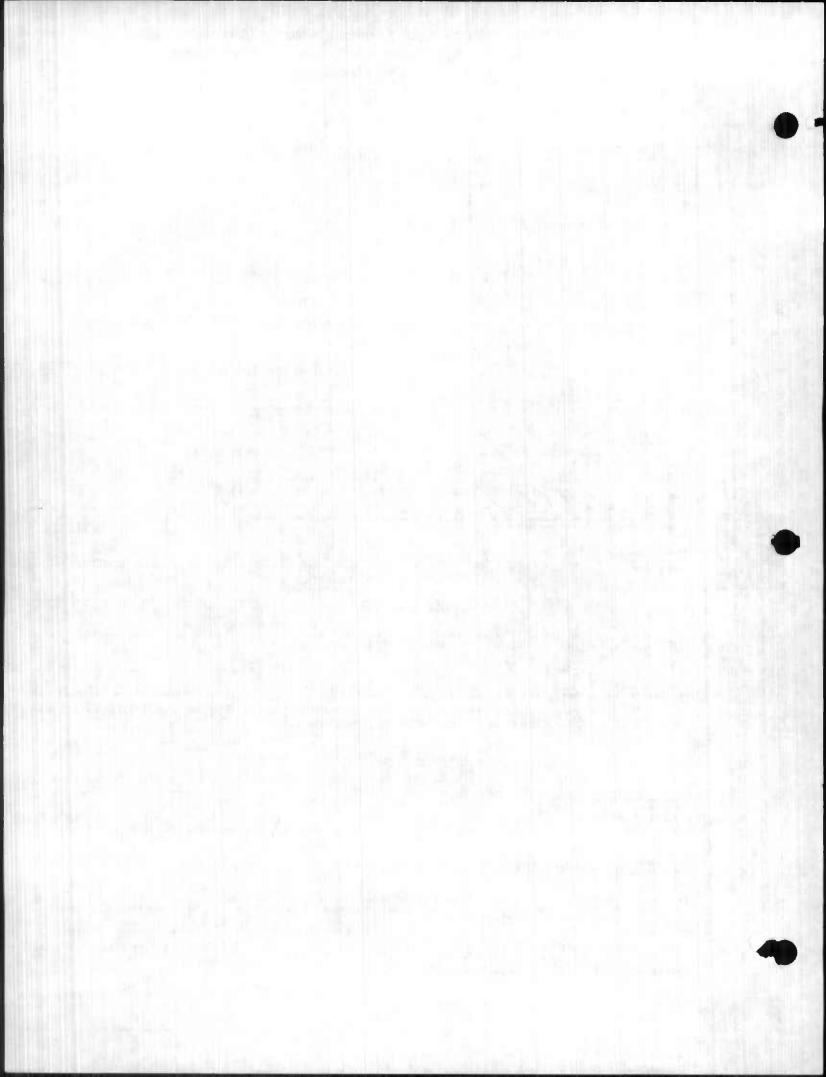
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State of Mandand / Department of Health and Montal Hydiana

			State of Mar		artment of F			giene () Reg. No.	0 29384
п	Dhusisian	1. Decedent's Name (First, Middle, L.	ast)				2. Dete of De Month	ath Day	3. Time of Death
	Physician /Medical	Nellie Lorraine	Dean				Sept	4 20	000 12:06 AM
	Examiner	4a Facility Nama (Il not institution, gi	ve street and number)			4b. City, Town, or Lo	ocation of Death	4c. County	of Death
		Talbot Hospice H	ouse			Easton		Talbo	t
	Funeral		Sex 7. Age (	In yrs. last birthdey	If Under 1 Year   Months   Deys	If Under 24 Hrs. Hours Min.	8. Deta of Bird (Month, Da	h Year)	Birthplace (State or Foreign Country)
ш	Director	216-18-2656	10 M 2 X F 7	6 Yrs.	Working Deys	Tiours IVIII.	Nov 18	, 1923	Maryland
	y .	Usual Residence of Decedent  10a, State 10b, County		Oc. City, Town or L	asstica				and Incide City I in its
	n the Maryland r Zla-f show positified at frector	10a. Stata 10b. County							10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	octo die s	Maryland Caroli	ne	Goldsbo					
	or 28e-f a be notified Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?
	To Kith	24215 E Cherry L			21636			USA	1
020	72 hours after death with the Marytan nearwal, or items 23e or 28e-f show idical Examiner must be notified at eted by Funeral Director	11. Merital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	12. Was Decedent Eve Armed Forcas? 1 Yas 2 No If Yas, Giva Yaar or Datas:	ar in U,S. 13.	Was Decedent of F If Yes, specify Cub 1 ☐ Yes 2 No	dispanic Origin? (Spean, Maxican, Puarto Specify:	ecity Yas or No Rican, etc.)	Specify.	- American Indian, k, Whita, atc. - black
Maryland 21215-0020		15. Decedent's E (Specify only highest gi	rade completed)	16e. Dece (Giv. lifa.	edant's Usual Occup a kind of work dona DO NOT use retire	petion during most of work d)	ing	16b. Kind of Bu	siness/industry
212	twithin the Man	Elementary/Secondary (0-12)	Coilege (1-4or 5+)		homemak	er		own	home
P	EIDE A	17. Father's Name (First, Middle, Las	1)			18. Mother's Name	(First, Middle,		
lar		Marshall Griffin				Emma Co	rrell		
ary	should nd Mer merks umetic To	19a. Informant's Name/Relationship	(Type, Print)	19b. Maii	ling Addrass (Street	and Number or Run	al Routa Numb	er, City or Town,	Stete, Zip Code)
	27 tra	Gaynelle Bledsoe	daughter	2013	Weber Dr	Forestv	ille.Ma	rvland	20747
6	-216	20a. Method of Disposition		20b. Place of Disp			Deta		City or Town, State
mo	Pages sent of mt. If th kry or o	1 ☑ Burial 2 ☐ Cremation 3 { 4 ☐ Donation 5 ☐ Other (Spec		Eastern	Shore	3	ept 11	Wurloc'	k,Maryland
Baltimore,	1 4 4 4 4	21. Signature of Furteral Service Lice		Veterans	Cemetery 2. Nama and Addra		.000	nulloc	K, Haly Land
ä	10000	b 1/1 / /	11.1		-	elfenbein			
		23a. Part1. Enter the disease, or cor	national that caused th			Greensbo			
		shock, or heart failura. List only	ona ceusa on each lina.	a daam. Do not ar	nai ina moda oi dyi	ng, sauri as cardiae i	or raspitatory of	1001,	Approximata Intarval Batween Onset end Death
	Physician /Medical	Immediate Causa (Final	1	0					
	Examiner	disease or condition resulting in death)	0.		incer				2413
	The second	A PROPERTY OF	Du	a to for as a conse	equance of):				1
	bysician and the burst-transit dical Examiner	Sequentially list conditions	b	e to (or as a conse	equance of):				
0	certificate be executed nding physician and use as the burial-transit n/Medical Examil	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury							
8760,	ohysicia the bur dical	thet initiated events rasulting in death) Last	CDu	a to (or as e conse	quence of):				
9	ng ph as th	rasulting in ooduly cast							
Вох	attending   affor use as clan/Me		d						
J.E	the atter the for in	Part II. Other significant conditions	contributing to death but r	not resulting in tha	undarlying cause gi	ven in Part I.	23b. Dld	tobacco use cor	tribute to the cause of death?
P.O.	ed by detac	Chronic O6	structle	Palmon	any Dis	ica se	1	2□ No	3 Probably 4 Unknown
of Vital Records,	aw requir							an autopsy rmed?	24b. Wara autopsy findings available prior to complation of cause of death?
0	The Late has page						10	Yes 22No	1 Yes 2 No
ita	certificate rector, pag	25. Was case referred to medical				26. Place of Deat	h (Check only	ona)	
>	2 000	examiner? 1 Yas 2 N6	Hospital: 1 Inpatient	2 ER/Outpatie	ent 3 DOA Ot	har: 4 Nursing Ho	me 5 Rasi	dence 6 Doth	ar (Specify) Hose ice House
	eath. or: After th the funeral cation:	27. Manner of Death  1. □ Natural 5 □ Pending	28a. Data of Injury (Month, Day Y	(ear) 28b. Time	of 28c. Inju	ry at	28d. Describe	how injury occurr	ed
0	Attending or death. ector: Afte by the fune iffication	2 ☐ Accident investigetic	on		M 1	Yas 2 No			
Division	tal or Attending P is after death.  al Director: After the funerated in by the funerated in Certification:	3 Suicide 6 Could not determined		- At home, farm, s	treet, fectory, office		28f. Location ( City or To	Street and Numb wn, Stata)	er or Rural Routa Number,
	Ceri Ceri								
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi		hysician: To the best of n miner: On the basis of ax and manner, states	amination and/or i					
	To the comple	295. Signature-and title of certifier	1	×	29c. Licen	sa number		29d. Data signed	d (Month, Day, Year)
		IC M	7 CU	8	1	47492	-	9/	7/00
		30. Name and address of berson who	completed cause of deat	th (Itam 23a) (Type	. Print)	Foldsbor	100 N	- 1/	3.
	State	31. Deta filed (Month, Day, Year)	32. Registrar's	Signatura /		20192800	o mi	116	30
	Registrar	SEP - 7 2000	/	o. ppo	als				



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State of Maryland / Department of Health and Mental Hygiene

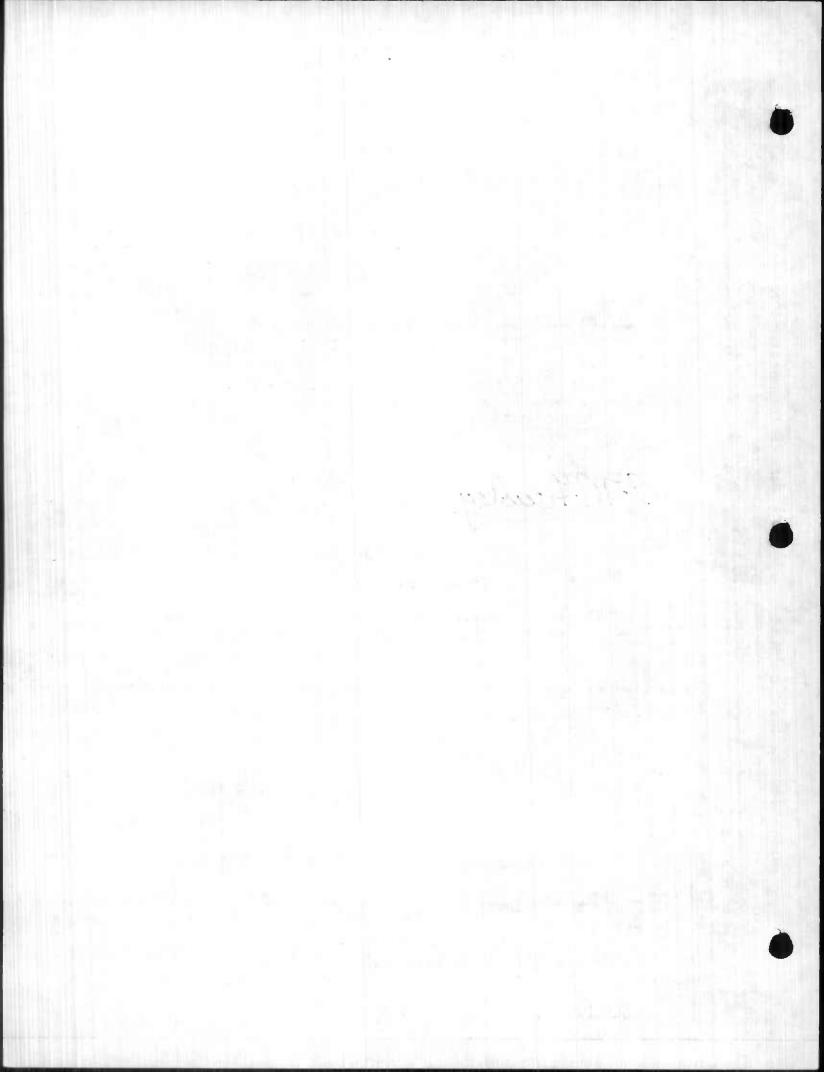
29385

				Ce	rtificate	of L	Death		Reg.	No.		
hysician /Medical	1. Decedent's Name (First, Middle, LORENZO			Ľ	UPREE			AUG	of Deeth h	Day 11, 2	.000	3. Time of Death 5:30 AM
Examiner	3641 ELDER OAKS						BOWIE	n, or Location of			y of Death E GEORG	GES
ineral rector	577 42 3401	Sex 1 M 2 F	7. Age (In yrs. last	birthday) Yrs.		eer lays	If Under 24 Hours	Hrs. 8. Date Min. JAN .	of Birth th, Day, Ye	1933	9. Birthpla Country WASHIN	ce (Stete or Foreign
flect.et	10a. Stete 10b. County MARYLAND PRINCE	GEORGES	10c. City, To	own or Lo	ocation						100	d. Inside City Limits 1 No 2 No
al Director	10e. Street and Number 3641 ELDER OAKS	BLVD. #5	5104	1	10f. Zip Co			w)			What Country STATES	
by Funeral	11. Marital Status  1 Never Married 2 Merried  3 Widowed 4 Divorced	Agned Fo	2 No		Wes Deceden If Yes, specify		spanic Origin, Mexicen, Specify:	in? (Specify Yas Puerto Rican, et	or No- c.)	Ble	ce · Americer eck, White, et fy: AFRO-	
Completed	15. Decedent's (Specify only highest) Elementery/Secondery (0-12)	Education grade completed) College (1	I-40r 5+)	(Give	dent's Usual C kind of work of DO NOT use i	ione du etired)	uring most o	of working		LIGIO	Business/Indu	stry
	12th 17. Father's Neme (First, Middle, La	st)						s Neme (First, A				
o Be	JUNIUS DUPREE	100						E SPICE				
-	19a. Informant's Name/Relationship	(Type, Print)	1	9b. Melli	ng Address (S			or Rural Route I		ity or Town	, Stete, Zip C	code)
	MARY R. ATKINSO	N(SISTER	2	2215	UNIVER	SIT	Y BLV	D. #301	НҮА	TTSVI	LLE, M	D 20784
	20a. Method of Disposition  1X Buriel 2 Cremation 3 4 Donation 5 Other (Spe	☐Removel from	20b. Plece	tery cre	osition (Nema metory or othe NATION	r Diece	CEMET	ERY 08/			City or Tow	n, State
pulce.	21. Signeture of Funeral Service of	prison A	Poer	E.		LEY	FUNE	RAL HOM		ATNTE	r Mn	20712
an al er	ahock, or heart failure. List on Immediate Cause (Finel disease or condition resulting in death)	a. CARI	DIO-RESPI	e conse	quence of):	EST						nterval Between Onset and Deeth
Examiner	Conventially list conditions	b	Due to (or as	_							1	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	COR	ONARY ART			Ξ						
Medical	Cause (Diseese or Injury that initieted events resulting In death) Lest	С	Due to (or as						, ik			
Jan/		d										
by Physician	Pert II. Other significant conditions END STAGE RENAI			g in the u	nderlying caus	e give	n in Part I.	236	Did tobe			the cause of death?
Completed b	HYPERTENSION				-			240	Wes an a performed		com	e autopsy findings lable prior to pletion of cause path?
E O	HEPATITIS C IN	FECTIONS							1 🗆 Yes	2 No	10	Yes 2□ No
Be	25. Was case referred to medical examiner?						26. Place o	of Death (Check	only one)	**		
To	1 Yes 2 No	Hospitel:	npatient 2 ER/	Outpatie		Other	4 Nun	sing Home 5	Residenc	e 6 🗆 Ot	her (Specify)	
ilon:	27. Menner of Deeth 1 Natural 5 Pending 2 Accident Investigat 3 Sulcide 6 Could not	ion he	th, Day Year)	o. Time o Injury	М		at ? 'es 2□N	0		injury occu		
Medical Certificat	4 Homicide determine	200. Plece	of Injury - At home, ng, etc. (Specify)	, ferm, sti	reet, factory, o	fice			tion (Stree or Town, S		iber or Hurel i	Route Number,
edical	29e. Certifier 1 Certifying F (Check only 2 Medical Ex-	eminer: On the ba	best of my knowled asis of examinetion ner steted.	lge, deatl and/or in	n occurred at t vestigation, in	he time my opi	a, dete end inion, death	plece, and due to occurred at the	o the caus time, dete	e(s) and m and place,	nanner as stat , and due to t	led. he cause(s)
2	290. Signature and the of certifier	ED/N	ephnolog	gist.			number )709				ed (Month, Da	
	30. Name and address of person who					NW,	WASH	IINGTON,				
State	31. Date filed (Month, Day, Year)	32. R	egistrar's Signature		-	-						

DHMH 16 Rev 6/95

Registrar

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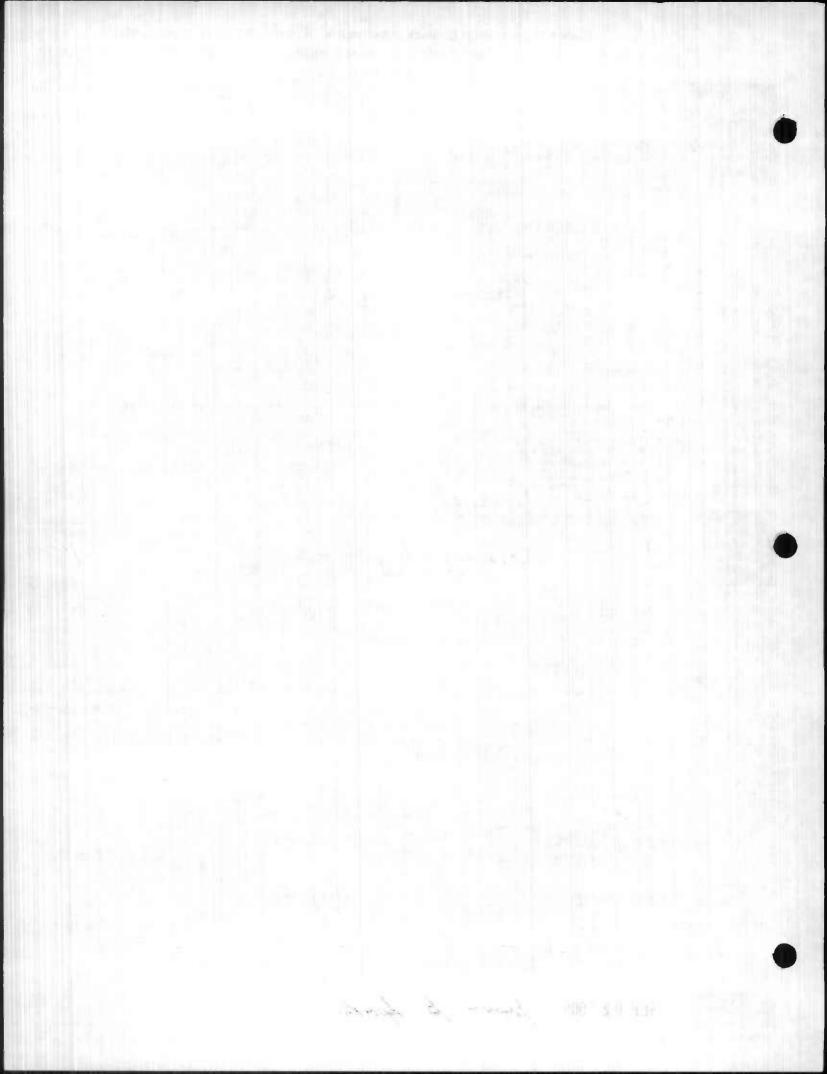
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2000 Sep 08:30pm King Virginia Margaret /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Cumberland Allegany Cumberland Nursing Home Hours Min. 8. Date of Birth (Month, Day, Year) Mar 11, 1910 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Days MD ( Months 1□ M 2□ F Yrs. 212-38-5674 90 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Meryland Department of Health and Mental Hygiene. Intropretant: If Item 27 is marked other than "naturef", or items 23s or 28s-f show eny Injury or other treumstic event, the Medical Error and Market 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Ves 2□No Directo Allegany Cumberland MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21502 320 Prince George Street Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ※☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. X Never Married 2 Married 1□ Yes 2□ No Specify: Specifichite by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondery (0-12) ret teacher elementary school 12 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Name (First, Middle, Last) (Griffin) Ellen Patrick King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 100 Wempe Drive; Cumberland, MD21502 Fran Catlett 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mary's Cemetery 9/06/ Cumberland, MD 21. Signature of Funeral Servica Licansee Scarpelli Funeral Home P.A. Cumberland, Maryland 21
23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical de seare an Examiner Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Last Due to (or es a consequença of): Records, P.O. Box 68760 Physician/Medical Due to (or as a consequenca of) 98 for use as ed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ been signated 24e. Was en eutopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? certificate has b 2 KNO 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Other: Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA shis After this funaral 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? Certification: 1 DNeturel 2 Accident 5 Pending 1 Yes 2 No thin 24 hours efter death.
the Funeral Director: Al death. investigetion 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and Illia 7 DO0 33280 2000 30. Name and address of purson who completed cause of death (Item 23a) (Type, Print) TUS 625 Kent Avenue Cumberland MD 21502 Gupta M.D. Sunil K.

32. Registrar's Signature

DHMH 16 Rev 6/95

State Registrar



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Lynch Robert Samuel SEPTEMBER 3, 2000 8:35 A.M. /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital & Medical Center Cumberland
If Under 24 Hrs. | 8 Allegany If Under 1 Year Hrs. 8. Date of Birth
MinSep 5, 1913 Birthplace (State or Foreign County) 5. Social Security Number 7. Age (In yrs. last birthday) XIOM 20F Months Days Hours 214-07-3384 86 Yrs Director Usual Residence of Decedent the Maryland r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits DIVECTO Yes 2 No Allegany Oldtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ir than "natural", or items 23s or 18601 Oldtown Road, SE 21555 USA Funeral 12. Was Decedenf Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married 1 ☐ Yes X ☐ No Specify: Baltimore, Maryland 21215-0020 Specify white p Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. 12 Elementary/Secondery (0-12) College (1-4or 5+) Retired Spinner Textile other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be 12 should be finance and Mental H Harry Lynch Beatrice (Shrout) 19a. Informant's Name/Relationship (Type, Print)
Barbara J. Bridges 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 233 Cessna Lane; Clearville PA 15535 permit. Pagas 1 and 2 sh Department of Health and Important: If Item 27 Is m any Injury or other traum price. daughter 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete X Burial 2 Cremation 3 Removel from State 4 □ Donation 5 □ Other (Specify) Branch Mountain Cemete 9/06/ Three Churches, Seampeldriss of the ral Home, P.A. Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feiture. List only one pause on much line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final diseasa or condition resulting in death) /Medical 3 DAYS . CEREBROVASCULAR ACCIDENT Examiner Due to (or as e consequence of): Examiner 24 HOURS b ASPIRATION PNEUMONIA Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): and signed by the attending physician doe detached for use as the burle Box 68760 Physician/Medical Due to (or as a consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Division of Vital Records, 24b. Were autopsy findings available prior to completion of ceuse of death? page 2 should Completed 24a. Was an eutopsy performed? peen this cartificata has 20 No 1 Yes 1 Yes director. Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: Inpatient examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 27. Marther of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? After Hospital or Attending 24 hours after death. 1 ANatural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29a. Certitier 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier 29c. License number D55079 SEPTEMBER 3, 2000 of 234) (1 30. Name and address of person wh completed ceuse of death (III The DR. PAULA WADDY 47 VIRGINIA AVE 21502 CUMBERLAND. MD 31. Date filed (Month, Day, Year) SEP 0 6 2000 State oaks Registrar

214-07-3384

ROBERT LYNCH

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State of Maryland / Department of Health and Mental Hygiene 00 29388

					Certifica	ate of	Death			Reg. No.		
Physicia /Medica	ın	1. Decedent's Name (First, Middle, L GLENWOOD RO	ast) YCE LOGS	SDON					2. Date of De Month Septem	ber Day , 20	) dg,	3. Time of Death 0131 AM
Examine		4a Facility Nama (If not institution, g SACRED HEART HO					4b. City, Too CUMBI		cation of Deat		of Death EGAN	
Funeral Director		236-68-4823	Sex 1X M 2□ F	ge (In yrs. last birt	hday) If Un Month	der 1 Year ns Days		Min.	8. Date of Bir (Month, Di JAN . 1	orth ny, Year) 8,1945	9. Birth Cou MAF	polace (State or Foreign intry) RYLAND
Maryland and and and	tor	Usual Residence of Decedent  10a. State 10b. County  WV MINE	RAL	10c. City, Town								10d. Inside City Limits
h with the	al Director	10e. Street and Number ROUTE 3, BOX	227		10f.	Zip Code 2675	3			10g. Citizen of U.S		intry?
nus 'i'	by Fur	11. Marital Status  1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 11/2 Yes 2 1 If Yes, Give Year or Detes:			cedent of pecify Cut		gin? (Spe , Puerto F	city Yes or No Rican, etc.)	5 Specifi	ck, White	ican Indian, , etc.
	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 12		F.A.	Decedent's U (Give kind of life. DO NOT ERK O	work done use retire	during most	of workin	g	16b. Kind of B		AILROAD
T D D D	To Be	17. Father's Name (First, Middle, Las MARVIN GLENN				4			(First, Middle)	ONES	ne)	
is 1 and 2 sho of Heelth and them 27 is ma other traums		19a. Informant's Name/Relationship CHERIE M. LO								CLEY, W		ip Code) 26753
A 70 A		20a. Method of Disposition  1XX Burial 2 Cremation 3  4 Donation 5 Other (Special Control of Contro		20b. Plece of cemeter, FORT A	y, crematory o	or other pla		9,	Date /7/2000	20c. Location FORT A		
pemit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Lice	Jachen C	h )	UPCH	URCH		AL HO	OME, II		26719	
Physician /Medical		23a. Par1. Enter the disease, or co shock, or heart tailure. List onl tmmediate Cause (Finat disease or condition	y one cause on each li	the death. Do none.	ot enter the m	ode ol dy						Approximate Intervat Batween Onset and Death
Examiner	Jer	rasulting in death)		Due to (or as a c	onsequence (	of):					1	1 hr
ertificate be ling physicia	Med	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	0.	Due to (or as a colle Acute Due to (or as a col	onsequence of	n): rdia:	L Infa	rctio	on		1	2 hrs
the d	Physician	Part II. Other significant conditions Asthma	contributing to death b	ut not resulting in	the underlyin	g cause gi	ven in Part f.			tobecco use co		to the cause of death?
the state of the s	Completed by F	ASUIIIA								s an autopsy ormed?	a	Vere autopsy tindings vallable prior to completion of cause if death?
Fall		25. Was case referred to medical							10		1	□Yes 25 No
3 0 2	To Be	examiner?	Hospital:	ent 2 PER/Out	patient 3	DOA O	hor-		(Check only ne 5□ Res	one) idence 6 □Oth	ner (Spec	eity)
Attending Physic death.  ector: After this by the funeral d	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation			ime of njury M	28c. Inju Wo	ryat rk? ]Yes 2∐ f		8d. Describe	how injury occur	rred	
ital or Attending irs efter death. el Director: Afte ied in by the fune		3 ☐ Suicide 6 ☐ Could not determine	28e. Place of Inj building, et	ury - At home, far c. (Specify)	m, street, fact	ory, office		2		(Street and Numi own, State)	ber or Ru	ral Route Number,
Hosp 4 hou Fune tely fil	edical		hysician: To the best of miner: On the basis of and manner sto	examination and								
10		29b. Signature and title of certified	Ben			29c. Licen D46	se number			29d. Date signe Sept. 6	-	
no hus		30. Name and address of person who William A. May				Cumb	erlan	d, MI	2150	02	N.	
State Registra	٠	SEP 0 7 2000	32. Registr	ar's Signature	Loa	6						

Registrar

supply and grant one of 423

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

29389 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death **Physician** : 45 AM RUTH A. LUDMAN /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** MANOR NURSING HOME LIONS CUMBERLAND ALLEGANY If Undar 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Sociei Security Number 6. Sex 7. Aga (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) Birthpiece (Stata or Foraign Country) **Funeral** Days 1□ M 2□ F 214-36-6222 Yrs Director 100 APR 11. 1900 PENNSYLVANIA Usuai Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. insida City Limits ns 23s or 25s-f show must be notified at 1 ☐ Yes 2 No MARYLAND ALLEGANY LAVALE 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21502 6 PARKSIDE BLVD Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. r than "natural", or item the Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Giva Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 💢 No by Specify: WHITE 3 X Widowad 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 EDUCATION 4 MUSIC TEACHER 17. Fathar's Name (First, Middle, Lest) 18. Mother's Neme (First, Middle, Meiden Surneme) Pages 1 and 2 should be I nent of Health and Mental ant; if Item 27 is marked of JOHN AULD MARGARET ROBERTS 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau QUAKER RD, PRINCETON JUNCTION, NJ 08550 DOROTHY MALCOLM/DAUGHTER 20b. Plece of Disposition (Neme of cematery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☑ Burlai 2 ☐ Cremetion 3 ☐ Ramovel from State SEPT SUNSET MEMORIAL PARK 11,2000 CUMBERLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerei Service Licensee 22. Name end Address of Facility HAFER CHAPEL OF THE HILLS MORTUARY 23a. Pert1. Enter tha disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest,

Apr. Approximete intarvei Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) . Chronic Renal /Medical Examiner trterioscleratic Vascular Disease The law requires that the death certificate be axecuted Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last the bunal-tran Due to (or es e consequence of) and Division of Vital Records, P.O. Box 68760 physician Physician/Medical Due to (or es a consequence of) Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? ate has been signed by page 2 should be detac 3 Probably 4 Munknown 1 Yes 2 No ongestive Heart Failure ò Completed 24b. Wera autopsy findings avellable prior to 24e. Was en eutopsy performed? ypertension completion of causa of death? 2 No After this certificate 1 ☐ Yas 2 ☐ No tal or Attending Physician: The state death.

al Director: After this certificate ed in by the funeral director, pa 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1. Neturei 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of fnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours af To the Funeral Di completaly filled is the Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end manner shifted. Medical (Check only one) 29b. Signetura and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) Ιũ 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Dr. Paul Snow 124 W. 3<sup>rd</sup> Street ( . Paul Snow Street umberland, Mb 21502 2. Registrer's Signeture State Registra

**DHMH 16 Rev 6/95** 

udman,

Amendel # 5, NRI, 9/2/00, Allegany Co.

### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death		Reg. No.	29390
		Decedent's Name (First, Middle, Last)	2. Deta of Dea	ith	3. Time of Death
	Physician	JOSEPH NEIL LIVINGSTON	Month AUGUST		Year 2000 13:46
	/Medical Examiner		Location of Death	4c. County of	Death
	L. Kullinio	John's Hopkins Hospital Baltimore		N/A	
	Funeral Director	5. Sociel Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Montha Days Hours Min			9. Birthplaca (Stata or Foreign Country)  Aaryland
	9	Usual Residence of Decedent	20000		
	nytan thow	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	cto diffe	Maryland Allegany Frostburg			1 XYes 2 No
	tor death with the Maryst flams 23s or 28s-f sho fort must be notified at Funeral Director	10e. Street and Number 180 E. Mechanic Street 21532-		U.S.A.	nat Country?
020	Exame	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Maxican, Puar If Yes, Giva Year or Dates:  13. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Maxican, Puar If Yes, Giva Year or Dates:	Specify Yas or No- to Rican, etc.)	14. Race Black, Specify: Whi	- Amarican Indian, White, etc.
20	72 ho	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of wo	orkina	16b. Kind of Busi	iness/industry
21215-0020	within the Me	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  12  (Give kind of work done during most of work life. DO NOT use retired)  student	, and	university	
			me (First, Middle,		)
Maryland	fental Had of	Joseph Livingston Paula Skip	oper		
ary	2 should and M is ment in ment	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Addrass (Street end Number or R	•	r, City or Town, S	tete, Zip Coda)
Ž	Para Maria	Paula Livingston mother 180 E. Mechanic Street Fro	ostburg	Marylai	nd 21532-
re,	Head Head of the state of the s	20a. Mathod of Disposition  20b. Place of Disposition (Name of cematery, cremetory or other place)	Data		ity or Town, Stete
Baltimore,	Pages ent of nt: it it	1 125 Burial 2 L.I. Cremation 3 L. Removal from State	03-Sep-00	Frostburg, A	Maryland
=	in in in in in in in in in in in in in i	21. Signature of Funeral Service Licenses 22. Name and Address of Facility			
Ba	Deg Man	The Reservet Durst Funeral Home, 57		_	MD 21532
i c		23a Part. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cardie mode, or heart failura. List only one ceusa on each line.	ic or respiratory ar	rast,	Approximata Interval Batween
	Physician				Onset and Death
Y	/Medical Examiner	Immediata Cause (Final disaase or condition resulting in death)  Cere bral henorthage			I day.
		Due to (or as a consequanca of):			
-	P = Q	cardiomyopathy			18 months
.60	ificate be executed 3 physician and as the burial-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events Due to (or as a consequence of):			
Box 68760,		reaulting in death) Last  Due to (or as a consequence of):			1
m	the death cert y the attendin sched for use hysiclan/N	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.	23b Did 1	obacco usa cont	ribute to the cause of death?
P.0	that the death certing of by the attending detached for use a Physician/M	The state of the s	10	5.0	3 Probably 4 Unknown
of Vital Records,	The law requires that sale has been signed by page 2 should be detacompleted by PI		24a. Was perlo	an autopsy med?	24b. Were autopsy findings available prior to complation of ceuse
Rec	The law sate has page 2 compl		400	(as a DA)	of death?
e	ificate or, pag	OF Was are adopted to medical	10)		1 ☐ Yes 2 ☐ No
N.	s certifical director, p	axaminar? A Heavitali Other	eath (Check only o		
ot	His di	1 Tes 2 at 140 1 Tes 1 parient 2 LEN Outpatient 3 LOOA 4 LINUising	Homa 5 ☐ Rasid	now injury occurre	
n	After funer funer	1) Naturat 5 Pending (Month, Dey Year) Injury Work?	200. 200.100		
Division	is after death.  In Director: After the funers of in by the funers.  Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At horna, farm, street, factory, offica building, atc. (Specify)	281. Location (S City or Tov	Street and Numbe vn, Stata)	r or Rural Route Number,
	illed Ce	One Codifies A Codifies Division Provided To the Codifies of t	and due to the	anunals) as i	nor se clated
	To the Hospital within 24 hours a To the Funeral Completely filled	29a. Certifier (Check only one)  **Certifying Physician: To tha best of my knowledge, death occurred at the tima, date and place (Check only one)  **Medical Examiner: On the basis of axamination and/or invastigation, In my opinion, death occurred at the tima, date and place (Check only one)	curred at the time,	date and place, ar	nd due to the causa(s)
2	within To the comple	29b. Signature and title of cartiller 29c. License number			(Month, Day, Year)
	3	M.D. RES-DO	1	AUGUST	0005,187
	ms	30. Name and address of person who completed ceusa of death (Item 23a) (Type, Print)  TOHN W. LIN M.D. TOHNS HAPILIN	e Horp	TTA:	
	State	31. Date filed (Month, Day, Year) SEP 0 5 2000 Separation of Spark	· CONP	TIAL	
	Registrar	OLI U D'EUR			

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Sup-00 Hostburg Maryland	feeting Memorial Park	

and Eugenet Moore, 57 Feed Ayer, Englishing AAD 21,552

EP 0 5 2000 James 10 dam

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	State of Maryland	/ Department of He	ealth and Mental Hygiene	939
		Certificate of L	Death Reg. No.	000
1. Decedent's Nama (First, Middla, Las	0		2. Data of Death	3. Tima of
LINDA	WOODRUFF	MAFFAY	September 02 2000	155
4a Facility Nama (If not Institution, giva	street and number)	41	c. City, Town, or Location of Death 4c. County of Death	

Physician /Medical Examiner

	Dor	chester	General	Hospita	IT.			Cambric	lge	Dorch	nester	
Funeral Director		34-3888	6. Sex 1□ M 2)		vrs. last birthda; Yrs.	y) If Uni	dar 1 Yaar is Days	If Undar 24 Hrs Hours Min	. (Month	f Birth h, Day, Year) 12 1915	9. Birthplaca (S Country) New You	
20		ace of Decedent		1400	City Town or I	Lanation			-		40d Inc	Ida Ciha i imita
rms 23s or 23s-f show r must be notified at neral Director	10a. Stata	10b. Coun		100.	City, Town or I		Jana					lda City Limits √Yas 2 □ No
be notified Director	MD		chester		Ca	mbri			74-11			F143 2 110
- Ha	10e. Street and						Zip Coda			10g. Citizen of		
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by Funeral		itus Married 2 ☐ Ma red 4 ☐ Divorce	Armined 1   N	Decedent Evar in ed Forcas? Yas 254 No as, Give r or Datas:	n 0,5.			dispanic Origin? (: an, Maxican, Pual Specify:	to Rican, atc	Bia Specif	ick, Whita, atc.	cari,
		15. Decede	ent's Education		16a Dec	edant's U	sual Occup	pation		16b. Kind of B	Businass/Industry	
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Be C	17. Fathar's N	ama (First, Middle	a, Last)			9.7		18. Mothar's Ne	me (First, Mi	iddle, Maidan Sumai	ma)	
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-	19a. Informan	t's Name/Ralation	nship (Type, Prin	1)	19b. Me	iling Addr	ass (Straat	and Number or F	lural Routa N	umber, City or Town	, Stata, Zip Coda,	
	Linda	M. Clar	k-daugh	ter	1417	7 Sto	ne Bo	oundary F	Rd., Ca	ambridge M	D 21613	
	20a. Mathod o				b. Place of Dis	position (/	Vama of		Data		- City or Town, St	ata
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	23a Parti Fi	ntar the disease	or complications	that caused this					-			oximete
- 88	shock, o	r haart failura. Li	st only ona cause	on aach lina.	addin. Donor o	WILOV (110 11	lodd or dy i	ng, such as cardie	o or raspirate	ory arraot,	interv	el Batween t and Deeth
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Examiner	Sequentially li	ist conditions, to immediata		Newy	o (or as a cons	equanca	01):	1 0 - 1			10	de .
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pa	resulting in de	ath) Last		Dua te	o (or as a cons	equanca o	or):					
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Physician/Med									1	m11		
Physician/Medical	Part II. Other a	lignificant condi	tions contributing	to death but not	rasulting in the	underlyin	g cause gi	van in Part f.	236.	Did tobacco use co		
4										1 ☐ Yes 2 ☐ No	3 Probably	4 EP Unknow
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Completed											of deeth'	Table 1
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10	1 Yes	2 No			2 ER/Outpeti		DOA	4 LI Nursing		Rasidenca 6 Ot		
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cat	2 Accide	OIII	tigation			М		]Yas 2□No				
E	4 Homi	data	mined 208.	Placa of Injury - A building, atc. (Sp.	At homa, farm, : ecify)	straat, fac	tory, offica			ion (Street and Num or Town, Stata)	nber or Rural Rout	a Number,
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edical	29a. Certifier (Check on	1)≦FCertify 2 ☐ Medica	al Examiner: On	tha basis of axan	knowledge, dar nination and/or	ath occurr invastigat	ed at tha ti	ma, data and place opinion, death occ	ca, and dua to curred at tha t	o the causa(s) and m tima, data and place	nenner as stated.  and dua to the c	ausa(s)
Med	one)	and title of an in		manner stated.		-	200 Lines	on number		20d Data size	and Manth Day	(oas)
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Registrar

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SEP 0.5 2000 James it francis

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29392 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month **Physician** Sept. 7, 2000 Mallery 6:30 a.m. Allen Harry /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Allegany 16701 Pleasant Walk Road # Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | Sep 23, 1934 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) 9. Birthplace (Steta or Foreign X 20 F **Funeral** 65 Washington, D.C. Director 217-32-2451 Usual Rasidence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes Z No Director Oldtown 288-1 Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò munt be USA 230 21555 16701 Pleasant Walk Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, 11. Maritaf Status Black, Whita, etc. 1 Never Married 2 Married 1□ Yes 2□ No natural', or 21215-0020 Specify: Specify: white by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry should be filed within 7 and Mental Hygiene. I marked other than "n urmitc event, the Medi Elamentary/Secondery (0-12) Collega (1-4or 5+) Retired CIA U.S. Government 12 Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Surname) Pages 1 and 2 should be nent of Health and Mental Helen L (Ely) Lawrence Winship Mallery 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 16701 Pleasant Walk Rd; Oldtown MD 21555 Sandra K. Mallery or other th Wol. Inched of Disposition 20b. Plece of Disposition (Nama of cematery, crematory or other place) Date 20c. Location - City or Town, State X□ Burial 2 □ Cremation 3 □ Removal from Stata 4 □ Donation 5 □ Other (Specify) Rocky Gap Veterans Cem9/11/ | Flintstone, MD 21. Signature of Funeral Service Licensee Scarpelli Fulleral Home, P.A. Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata fntervel Between Onset end Death **Physician** /Medical Immediate Cause (Final disaasa or condition rasulting in death) Examiner Dua to (or as a consequence of): Examine Dua to (or as a consequence of): orton ician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiata causa. Enter Undarlying Cause (Disaase or Injury that initieted evants resulting in death) Lest Box 68760, Physician/Medical Dua to (or as a consequence of): 980 P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HICHF , Hype Records, þ 5.8 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yas 2 BNo 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: Be 25. Was casa rafarred to medical examiner? 26. Place of Death (Check only one) To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) Certification: 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Division 1 Natural To the Hospital or Attandil within 24 hours after death. To the Funeral Director: A 1 Yes 2 No 2 Accident 6 ☐ Could not be datermined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifiar Medical 1/2 Certifying Physician: To the best of my knowledge, deeth occurred at the tima, date end place, end due to the cause(s) and menner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier elev h N D17565 Sept. 7, 2000

Registrar **DHMH 16 Ray 6/95** 

nus

State

tarry Allen Mallery

Anthony J. Bollino, Jr.; 922 National Highway; LaVale, MD 21502

22. Registrar's Signature

30. Nema and addrass of person who completed causa of death (ftem 23a) (Type, Print)

0 8 2000

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

						Certifica	te of	Death		Reg. No.	0 23	
		1. Decedent's Neme	e (First, Middle, La	ist)					2. Date of Dea Month		Year 3. Ti	me of Death
Physici /Medic		John		Henry	Ma	artin			Aug 29	, <sup>2</sup> 000	07:	21pm
Examin		4a Fscility Name (II	f not institution, giv	e street and num	ber)			4b. City, Town, or	Location of Death			
5 <u>11</u>	٠.	111 Mas	sachuse	tts Av	enue			Cumberl			Allegan	У
Funeral Director		5. Social Security N 215-20-	5279	Sex IDM 2DF	7. Age (In yrs. last b	Yrs. If Und Months	or 1 Year Days	If Under 24 Hr Hours Mir	6. Dete of Birt (Month, Day OCT 29,	1927	9. Birthplace (S Country) MID	tate or Foreign
pul .		Usual Residence of 10a. State	Decedent 10b. County		10c City To	wn or Location					10d Inei	ide City Limits
ahow	2											Yes 2 No
ith the Maryla or 28s-f ahor	Directo	MD 10e. Street and Nur	Alleg	any		Cumberl	and ip Code			10g. Citizen of V	41	
£ 0 4	al Dir	111 Mas		tts Av	enue	101. 2	ip Coos	21502		USA	What Country?	
5-0020 72 hours efter deeth internet, or theme 23	by Funeral	11. Marital Status  1 Never Merri  3 Widowed	ed 2 Married 4 Divorced	Armed Ford	2□NoWW I.	I 13. Was Dec If Yes, sp 1 ☐ Yes			Specify Yes or No- rto Rican, etc.)		ck, White, etc.	in,
72 houn	Completed	/Snec	15. Decedent's E	ducation	16	a. Decedent's Us	ual Occu	pation	ndrina	16b. Kind of B	usiness/Industry	
Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z	d d	Elementary/Secon		College (1-	4or 5+)			during most of wo				
	Co	12			re	tired 1	.ieu				ire Dep	T
be filed tel Hygin	Be	17. Father's Neme (							me (First, Middle,		ne)	
yland ould be file Mentel Hyr arked othe	2	William	Thomas	Marti.	11			Lucy C	. (Dres	ssman)		
Mar and 2 sh aith end 27 le m	- 1	19a. Informant's Ne Dolores	Martin	Type, Print)	15	b. Mailing Addres	ss (Stree sach	usetts	Aven; Cu	n. City or Town. Imberla	State, Zip Code) and, MD	21502
		You. Method of Disp			comol	of Disposition (N.	ame of	aca)	Dete	20c. Location	City or Town, Ste	ite
Saltimore emit. Pages 1 a appartment of He montant: If her ny injury or oth			☐ Cremetion 3 ☐ 5 ☐ Other (Specif		tete				9/02/	'umbor'	land M	D
Dealtim Department Mportant: Inny Injury once		21. Signature of Fu			Sunse				al Home		rand, M	D
D ed E		Min	10 h no	1 10	MANIA	-		nd, Mar		21502		
		23a. Pert1. Enter the shock, or hear	e disease, or com	diculions that ca	used the death. Do				-		Appro	ximate
. BOX 08/00, death certificate be executed e attending physicien and d for use as the burlat-transit	Medical Examiner	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or that initieted events resulting in death) L		b		a consequence of	): D	z bu	vgs			
Boath cer attendin	Physician/				- Ca		, _	9				
	ysi	Part II. Other signifi	cant conditions of	contributing to dea	ith but not resulting	in the underlying	cause g	iven in Pert I.			ontributs to the ca	
	4								10	Yes 2 No	3 Probably	4 Unknow
ne lew requires ti s has been signe ogs 2 should be	Completed by									an autopsy med?	24b. Were auto availeble completio of death?	prior to in of cause
The lew ste has b page 2 s	Ĕ								100	es 212 No	1 ☐ Yes	
Physician: The lithic certificate he ral director, page		25. Wes case referr	ed to medical					OC Pleas of D			10 163	20140
Physician: this certific	0 Be	examiner?		Hospitel:	patient 2 ER/0	Outpatient 3 0	0	ther	eath (Check only of Home 5 12 Resid		nes (Canaile)	
0 £ £ ā		27. Manner of Death		28a. Date of (Month		. Time of	28c. Inju		28d. Describe			
Attending ir death. ector: After by the fune	Certification:	1 Divetural 2 Accident	5 Pending investigation		, Day Year)	Injury M		ork? ]Yes 2∐No				
l or Attending efter death. Director: After d in by the fune	fica	3 Suicide	6 Could not b	e des Disses	of Injury - At home,	farm, street, fecto			28f. Location (5	Street and Numi	ber or Rurel Route	Number,
Page 2	To	4  Homicide	Getermined	building	g, etc. (Specify)		,		City or Tou	m, Stete)		
To the Hospital or Attending Ph within 24 hours after death.  To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	nysician: To the baseliner: On the baseliner	est of my knowledges of examination s	ge, death occurre and/or investigation	d at the t	ime, date and place opinion, death occ	e, and due to the curred et the time,	cause(s) and midate end place,	anner as stated. and due to the ca	use(s)
of the of the office of the of	¥	29b. Signature and	title of certifier	1		2	9c. Licen	se number		29d. Dete signe	ed (Month, Day, Yo	ear)
2		1 gol	an 19	eha	nas	(N-D	D17	526		Aug :	31, 200	0
		30. Name affid address John N	ess of person who Mehanr				lve	Cumberl	and MD	21502		
Sta Registra		31. Date filed (Monti	UG 3 1 2		gistrar's Signature	6	par	4		1,676		
		,,		1		10 19	Nou	as I				

DHMH 16 Rev 6/95

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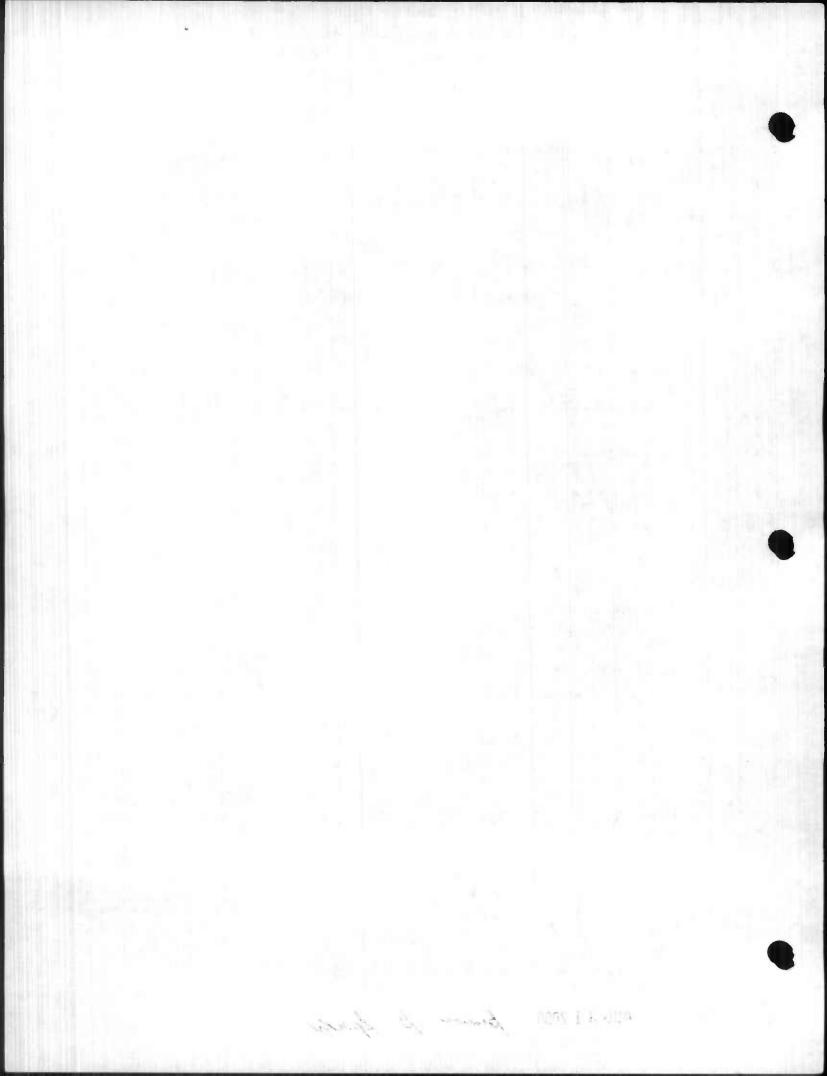
ALCOHOLD STREET & STREET

220-28-9956

RUTH MILLER

	Decedent's Name (Firs.)	Middle 1	net)		Cen	tificate of	Death	2. Data of D	Reg. No.		3. Time of Do
cian	RUTH PEARI		LER					Month	Day	Yaar	
dical iner	4a Facility Name (If not in			ber)			4b. City, Town	August n, or Location of Dec	30, 200 ath 4c. County		5:35 A.
miei	Memorial Hos			00	ter		Cumber	1and	Alleg	anv	
al	<ol><li>Social Security Number</li></ol>	6.		. Aga (In yrs.	last birthday)	If Undar 1 Year Months Days	r If Undar 24	Hrs. 8. Date of 8	Birth Day, Year)		place (State or F
r	220-28-9956 Usual Residence of Dece		IUM 265F	70	Yrs.			SEPT 1	4 1929	W.VA	
-		County		10c. Cit	y, Town or Loc	ation					10d. Inside City
tor	MARYLAND	ALLE	GANY		FLIN	TSTONE					1 ☐ Yes 🏖
J'e	10a. Street and Number				0.15	10f. Zip Code			10g. Citizen of	What Cou	ntry?
ral	11014 M.V. S	MITH				21530			U.S		
by Fur	11. Marital Status  1 □ Never Married 2  3 ☒ Widowed 4 □ D		12. Was Deced Armed Ford 1 Tyes of If Yes, Give Year or Da	ces? 2 \( \) No		/es Decedent of Yas, specify Cul ☐ Yes 2X No		n? (Specify Yes or I Puarto Rican, atc.)	Bia	ck, White,	
Completed		ecedent's E	ducation ade completed)		16a. Decede	ent's Usual Occu	spation e during most o	of working	16b. Kind of B	usiness/In	dustry
E I	Elementery/Secondary		College (1-	4or 5+)	life. D	ONOT use retin	ed)		HOM	TO DATA TO	ED
	17. Fathar's Nama (First,	Middla, Las	1)		ПОГЛ	L PIAKEK	18. Mother's	s Name (First, Midd		E MAK	LK
To Be	ELMER ANDRE							MAE MORG			
-	19a. Informant's Name/Re	elationship	(Type, Print)		19b. Meiling	Address (Stree	et and Number	or Rural Route Num			
	CRYSTAL DUC	KWORT	H	NIECE	805 S	. MARYL	AND AVE	E CUMBERI	LAND MARY	LAND	21502
	20a. Method of Disposition 1 XBurial 2 ☐ Cren		Removal from S	tate		atory or other pla		Date	20c. Location	- City or T	own, State
	4 Donation 5 DO			SUN	SET CE	METERY S	SEPTEMB	ER 1 2000	CUMBERL	AND N	IARYLAND
	21 Signature of Funeral S	Service Lie	79 -	N		Nama and Addr		NERAL HOM	E P.A.		
	23a. Part1. Enter the dise	7.	Lemb	(	404	4 DECATE	JR STRE	ET CUMBER	LAND MAR	YLANI	Approximate
Examiner	Sequentially list condition if any, leading to immadia cause. Enter Underlying Couse (Disease or Injury	s, te	b. CORON.	ARY ART	r as a consequence of as a consequence of as a consequence of a consequenc	SEASE				- 1	10 MONT
O	Cause (Disease or Injury that initiated events resulting in deeth) Last	ĺ	d.		r as a consequ	anca ot):					J TEAR
SICIE	Part II. Other algnificant of	onditions	contributing to dea	ath but not res	ulting in the un	derlying cause g	given in Part I.	23b. D	d tobacco uss co	ontribute	to the cause of
Phy								11	Yss 2□No	3 Pro	bably 400
Completed by								24a W	as an autopsy	24b. W	/ere autopsy tin-
ete								pe	normed?	0	vailable prior to ompletion of cau deeth?
E O								10	Yes 2 No	0.00	Yes 2 N
-	25. Wes cese reterred to	medical					26. Place of	of Death (Check onl	/\		
ToB	examiner?		Hospital:	patient 2	ER/Outpatient	3□ DOA O	Whor:	sing Home 5 Re		her (Spec	ity)
	2 ☐ Accident	Pending investigation			28b. Time of Injury		Yes 2□N	0	e how injury occu		m I Bouto Alumba
ertit	4  Homicide	determined	buildin	g, etc. (Specif	y)	et, tactory, office	9		Town, State)		
edical C	29a. Certifier (Check only one) 2 M	ertifying Pl edical Exa	hysician: To the to miner: On the ba- and mann	sis/of examine	wledge, death tion end/or inv	occurred at the sestigetion, in my	time, date and opinion, death	place, and due to the control occurred at the time	ne cause(s) and m e, dete and place	anner as , and due	stated. to the cause(s)
	29b. Signatura and title of	certifier /	1/			29c. Licer	nse number		29d. Date sign	ed (Month	, Day, Year)
Σ			1-20			D2676	6		August	30	2000
2	1	- u	4.4			D3676	0		1146400		2000
	30. Name and address of	person who	completed ceuse	ot death (Iten	n 23a) (Type, F		0		nagase		2000
2	30. Name and address of Dr. Vik Poon 31. Date tifed (Month, Da)	ai, 9	20 Natio		ghway,	Print)	1/2 51	21502	nagase	/	2000

DHMH 16 Rev 6/95



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death MAY

3	/Medic	Physician /Medical Examiner					
	Funeral Director						

Nerva 23a or 28a-f show ner must be notified at Director Funeral В

hours after 2 filed within is marked or reumatic ev Department of Health ar Important: If Nem 27 is any injury or other trau

altimore, Maryland 21215-0020 Completed 88 Pages 1 and 2 should be nent of Health and Mental Physician /Medical Examiner Physician/Medical Examiner The lew requires that the death certificate be executed pue Box 68760. signed by the at d be detached for P.O. Division of Vital Records. by Completed or Attending Physician: funeral director, Be Certification: To this After To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely lilled in by the fun Medical En V

1. Decedent's Name (First, Middle, Last) r 1, 2000 September Donna 4:00 A.M. 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 425 Fayette Street Cumberland Allegany If Under 24 Hrs. If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Deys Months 1□M 2♥F 63 Yrs. 236-54-9026 Aug. 3,1937 WEST VIRGINIA Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Allegany Cumberland 1X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 425 Fayette Street 21502 U.S.A. 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus 17 Yes 2 No if Yes, Give Yeer or Detes: 63-64 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3√ Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Induatry Elementary/Secondery (0-12) College (1-4or 5+) Registered Nurse Nursing 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Gladson W. Allamong Beatrice Camp 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) John D. May, II / Son 425 Fayette Street, Cumberland, MD 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from Stete 4 Donetion 5 Other (Specify) M.S.V.C.-Rocky Gap 19/5/00 Flintstone, MD 21. Signeture of Funeral Service Licenses 22. Name and Address of Fecility Upchurch Funeral Home, P.A. 202 Greene St., Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediete Cause (Final disease or condition resulting in deeth) AMYOTROPHIC CATERAL SCLETOSIS 3 MONTHS Due to (or as a consequence of) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or es a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part f.

CARONIC OBSTRUCTURE PULMONARY PISCASE

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Wes en autopsy performed? 1 Yes 2 No 24b. Were eutopsy findings available prior to completion of cause of death?

26. Place of Death (Check only one)

1 Yes 2 LING

25. Was case referred to medical examiner? 1 Yes 2 No 27. Menger of Death

1. Netural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

5 Pending investigation 6 ☐ Could not be determined

28e. Dete of Injury (Month, Day Year) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

(Check only one) 29b. Signature and title of certifier

Pary SICIAN

29c. License number 250844 29d. Date signed (Month, Day, Year)

person who completed cause of deeth (Item 23a) (Type, Print) 30. Neme and addr DET.

912 SETON DRUKE CUMBERLAND MD 21502 (DVERLA JR. MA)

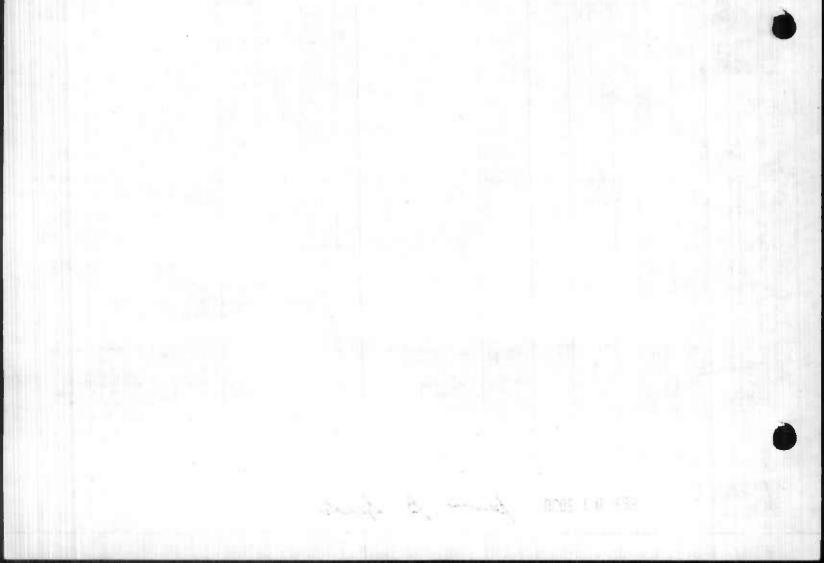
(Manth, Dey, Year)

SEP 0 1 2000 32. Registrer's Signeture

**DHMH 16 Rev 6/95** 

State

Registrar



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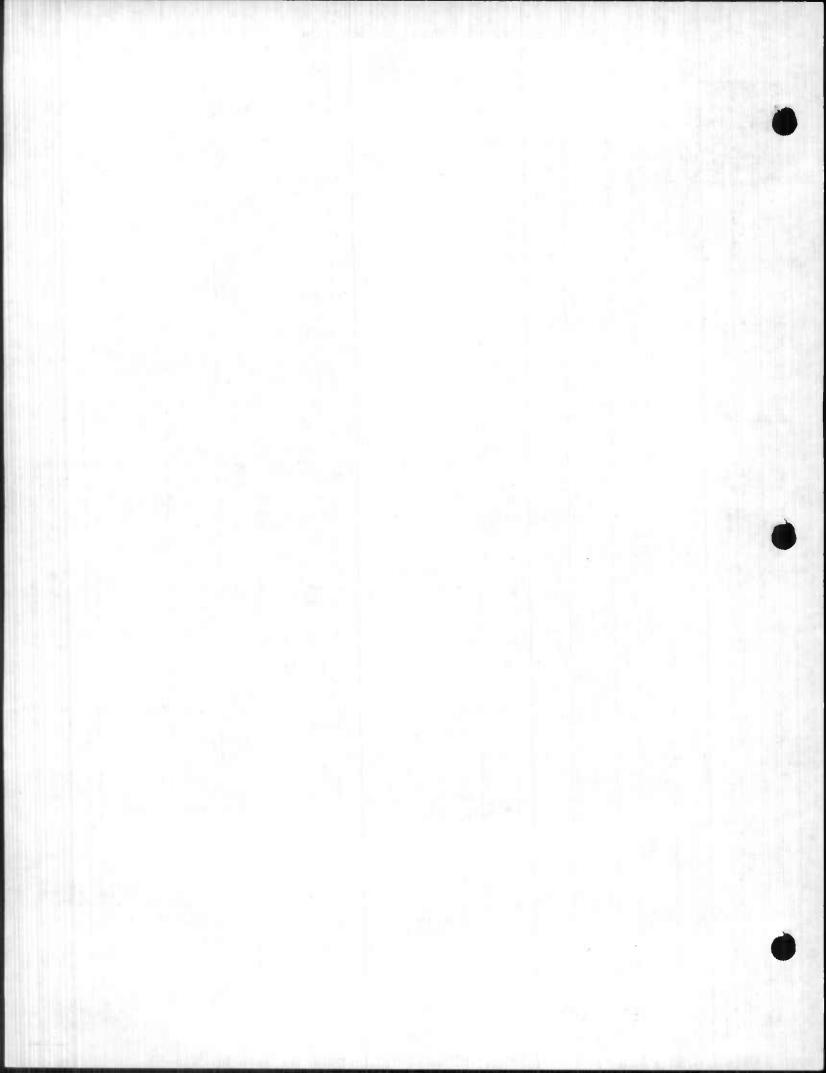
State of Maryland / Department of Health and Mental Hygiene

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				Cei	tificate	UI L	Juani		P	leg. No.				
	1. Decedent'e Nama (First, Middle	a, Last)							2. Data of Dea		Mana	3. Tima of Death		
nysician	Ruth E.		N:1110						Month	B 2	Yaar	1,05 AD		
Medical xaminer	4a Facility Nama (If not institution					4	b. City, Tov	vn, or Lo	cation of Death	4c. Count				
Kanımei	Howard County	Conoral He	enital			1	Columb	nia		Howa	rd			
	5. Social Security Number	C Cau 7	. Age (In yrs. last	birthday)	If Under 1		If Under 2		8. Data of Birth	1	-	place (State or Fore		
neral ector		1 M 2 F		Yrs.	Months I	Days	Hours	Min.	(Month, Day	(Month, Day, Year) Country)				
Cloi	Usual Rasidance of Decedant	5-52-0436							Dec. 1	1, 1936		Texas		
	10a. Stata 10b. County		10c. City, T	own or Lo	cation							10d. Insida City Lim		
5	MD Howar	44	Lau	ron.								1 Yas Z		
Director	MD Howar	La	Lau	rer	10f. Zip C				10.000			nter?		
ㅎ	Toe, Street and Number				Tot. Zip C					10g. Citizan of What Country?		intry :		
Funeral	8262 Rippling				_	20723 of Hispenic Origin? (Specify Yes or N Cuban, Maxican, Puarto Rican, etc.)			USA					
au.	11. Marital Status	12. Was Deced Armed Forg	2. Was Decedant Ever in U,S. Armed Forces 1 1 Yes, specify 1 Yes 22 No						t of Hi	lo- 14. Race - American Indian, Black, Whita, atc.				
	1 Never Merried 2 Man	W VAC GIVE	<b>Ø</b> No		1 Yes 25	No S	Specify:			Specia	v: Wh:	ite		
i by	3 □ Widowed 4 ♣ Divorced	Yaar or Det								Option.	y	100		
tec	15. Deceden	t's Education st grade completed)		6a. Deced	dant's Usual ( kind of work	Occupa dona	ation	of worki	20	16b. Kind of E	Business/Ir	ndustry		
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Completed	12	Ø		Sec	cretary	1				Southl	and	Corporati		
Be C	17. Father's Neme (First, Middle,	Last)					18. Mothe	r's Nama	(First, Middla,					
0 8	Eddie Kurets	ch					Lve	dia 1	Bletsch					
T BEE	19a. Informant's Name/Ralations			10b Mailir	an Address /	Stroot			l Routa Numbe		State 7	in Code)		
	Robert Miller/S	Son			RIPPI:		Bran	cn R	oad, La					
	20a. Mathod of Disposition	3 Namoval from St	0.000	atary, cran	natory or other	ar plac	e)	1	Defa	20c, Location	- City or I	own, State		
	4 Donation 5 Othar (S			nity	Luther	can	Cem.	9	/14/00	Riesel	, Te	xas		
	21. Signatura of Funaral Sarvice	Licansaa			Nama and			v .						
	165											ome, P.A		
	220 Part Fotor the disease of	complications that one	MOO770						, Laure		20/0/	Approximate		
	23a. Part1. Entar the disaasa, or shock, or haart failura. List	only ona causa on aad	ch lina.	DO HOL GIR	or the thous	or dywn	g, such as	out diac c	i toophatory as	1031,		Interval Between Onsat and Deatl		
n												011001 0110 00011		
ıl r	Immediate Causa (Finat disaasa or condition	1-1	VER	LUI	LURE						1	2 ~ 2		
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Examiner	Sequentially list conditions.	b	Dua to (or es	a conseq	uance of):									
Ä	if any, leading to immediata causa. Enter Undarlying										i			
edicai	Sequentially list conditions, if any, leading to immediata causa. Enter Undarlying Cause (Disease or injury that initiated avants	С	Dua to (or as	e consec	uence of):						-			
8	rasulting in death) Last		Dua to tor as	a conseq	darios orj.									
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/sic	Part II. Other algnificant condition	onditions contributing to death but not resulting in the underlying cause given in Part t.					23b. Did tobacco use contribute to the cause of de							
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by	Taristical I		to Alix	""										
sate has been signed by the attend , page 2 should be detached for us  Completed by Physiciany	T 1								24a. Was	an autopsy med?	a	Vara autopsy findin vailable prior to		
	Inviduce 1								p 5.70		0	omplation of cause f death?		
E									101	as 20 No		□Yas 2□No		
certificate has rector, page 2 Be Comp							20.5	4.7		//		2140 20110		
O	OF Monage estate day	41 21 6				Oth	ar:		(Check only o					
Be	25. Was casa ratarred to medica examinar?	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 8 Other (Specify)										rify)		
To Be	examinar?	1	28e. Data of Injury (Month, Day Year) 28b. Tima of Injury at Work?						28d. Describe how injury occurred					
To Be	examinar? 1 Yes 2 No 27. Mannar of Death		M 1 Yas 2 No											
To Be	examinar? 1	ng (Month, gation									28f. Location (Street and Number or Rural Routa Number, City or Town, State)			
To Be	examinar?  1 Yes 2 No  27. Mannar of Death  1 Natural 5 Pandir 2 Accident Invastir 3 Suicide 6 Could	gation (Month)	f Injury - At home	ı, farm, str		office					ber or Ru	ral Routa Number,		
To Be	examinar?  1 Yes 2 No  27. Mannar of Death  1 Natural 5 Pandir 2 Accident Invastir 3 Suicide 6 Could	gation (Month)	f Injury - At home g, atc. (Specify)	ı, farm, str		office					ber or Ru	ral Routa Number,		
Certification: To Be	examinar? 1 Yes 2 No 27. Mennar of Death 1 Natural 5 Pandir 2 Accident Invasti 3 Suicide 6 Could 4 Homicide	ng (Month, gation not be nined 28a. Place o building	, atc. (Specify)		reel, factory,		ne, date an		City or Tow	vn, State)				
Certification: To Be	examinar?  1   Yes 2   No  27. Mannar of Death  1   Natural   5   Pandir   2   Accident   Invastir   3   Suicide   6   Could   4   Homicide    29e. Certifier   1   Certifyin	gation not be inned 28a. Place o building ag Physician: To tha b Examiner: On the bas	a, atc. (Specify) est of my knowle	dge, death	reel, factory,	the tim	ne, date an	d placa, a	City or Tow	vn, State) causa(s) end n	nannar as	stated.		
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State of Maryland / Department of Health and Mental Hygiene 00 29397

					C	erti	ficate	of i	Death			Reg. No	),			
100.00	_	1. Decedent's Name (First, Middle,	Last)						Men.		2. Date of De Month	ath		Year	3. Time	of Death
Physicial	_	FANNIE KATHER	INE POT	ידיכ							August			2000	4:	23 P.M
/Medica Examine	-	la Facility Name (If not Institution,						-	4b. City, To	wn, or L	ocation of Deat		County			
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and and and and and and and and and and		GARY E. MULLIGAN		SON					Y DRI	VE	STATE C					
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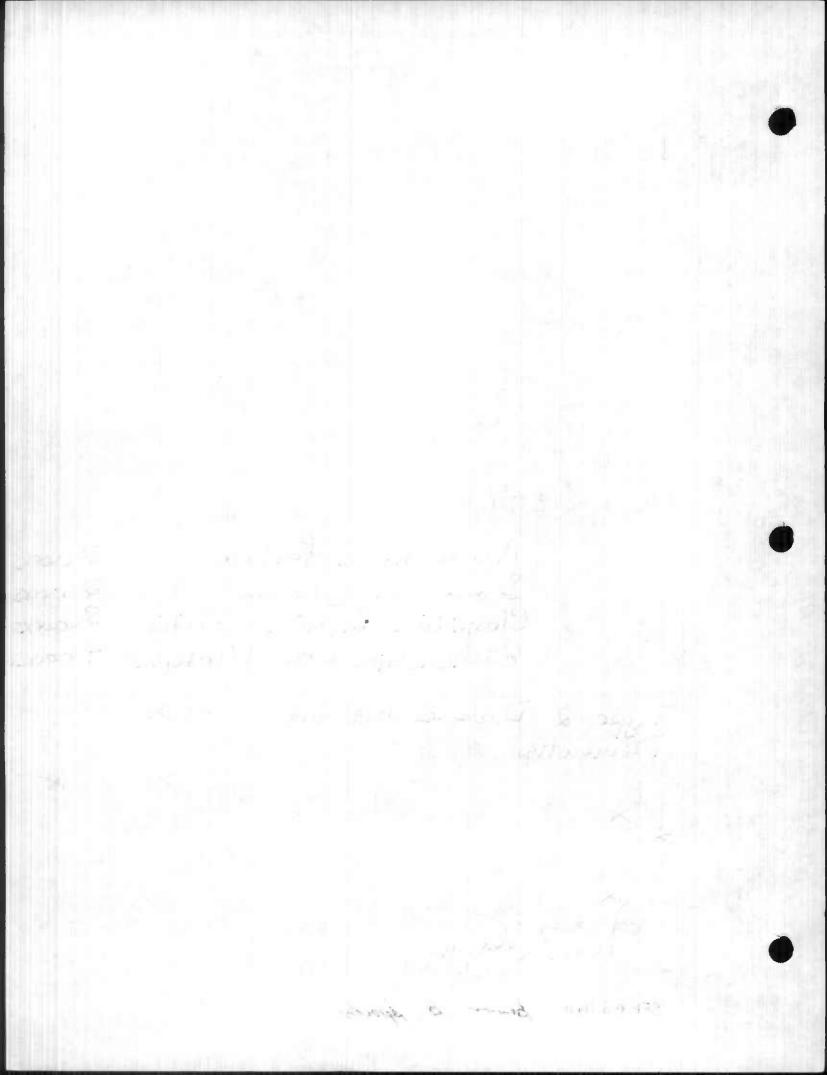
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State of Maryland / Department of Health and Mental Hygiene 1 29398

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	1. Decedent's Name (First, Middle	e, Last)							2. Dete of Der Month	ath Day	Year	3. Time of Death
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neral rector	5. Social Security Number 214-05-6092	6. Sex 1 M 2 F	. Age (In yrs. last b	Yrs.		Deys	Hours	Min.	8. Dete of Birt (Month, De JAN . 17	7, Year) 1901	Cour	lace (Stete or Foreign stry) Y LAND
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rector		EGANY		BERL								1 XYes 2 No
9	10e. Street and Number	JOANI	COP	IDEKL	10f. Zip C	ode		-		10g. Citizen of	What Cour	ntry?
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	15. Decedent			e. Decede	nt's Usuel	Occupa	ation			16b. Kind of B	usiness/In	dustry
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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEP 4:30Pm 2000 DENISE M. RUSSELL 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore tospita NONE If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) Days Months Hours 1 M 20 F Yrs. 180-54-0385 42 March 31,1958 Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Maryland Howard Ellicott City 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4466 Rolling Meadows 21043 United States 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. 11. Meritel Status Armed Forces? 1 Yes 2 XNo If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 Merried 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 4 Registered Nurse Healthcare 17 Father's Nema (First Middle I ast) 18 Mother's Neme (First Middle Maiden Sumame) Michael Marich Marcella Sienkiewicz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. fnforment's Neme/Reletionship (Type, Print) 4466 Rolling Meadows Ellicott City, MD 21043 James M. Russell/Husband 20e. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Steta 1 ₺ Buriel 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) St. John's Cemetery 9-11-2000 Ellicott City, MD 22. Name end Address of Facility 21. Signeture of Funerel Service Licensee M01044 Harry H. Witzke's Family Funeral Home, Inc. Show a Coll 4112 Old Columbia Pike Ellicott City, MD 21043 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) metastatic LUNG cancer Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Pert II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28e. Dete of tnjury (Month, Day Year) 27. Menner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of fnjury - At home, ferm, street, factory, office building, etc. (Specify)

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Physician/Medical P Completed 86 10 Certification: after deatl Director:

**Physician** 

/Medical

Examiner

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**Funeral** 

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Department of Important: If any Injury or

Physician

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Pages 1 and 2 should be filed within

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Baltimore, Maryland

8 within 24 hours of to the Funeral Completely filled edical 8 5 State 4 Homicide

(Check only one)

29b. Signeture end title of certifier

VUNNE

31. Dete filed (Month, Dey, Year)

29e. Certifier

Registrar

**DHMH 16 Ray 6/95** 

SEP 1 1 2000

OIL



MD

- MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OTTAVIANO

900 CATON AVE

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

D40850

29d. Date signed (Month, Day, Year)

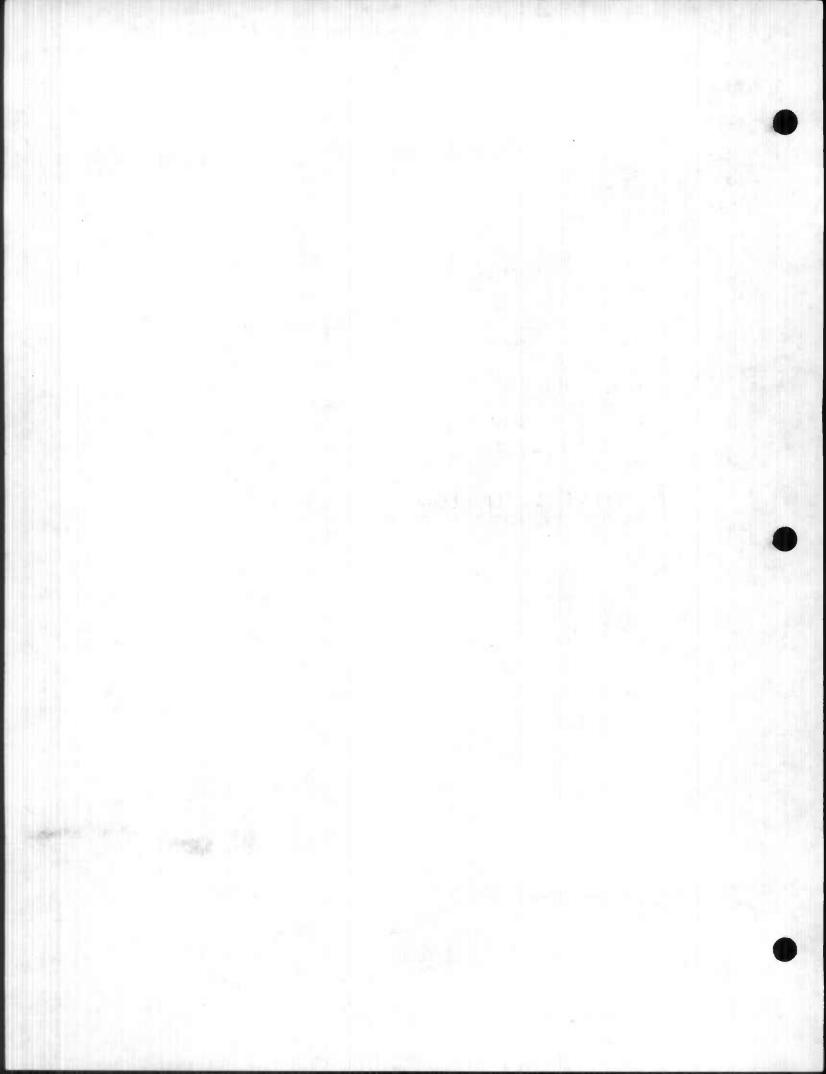
September 7, 2000

BALTIMORE MUZIZZ9

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State of Maryland / Department of Health and Mental Hygiene 00 201,00

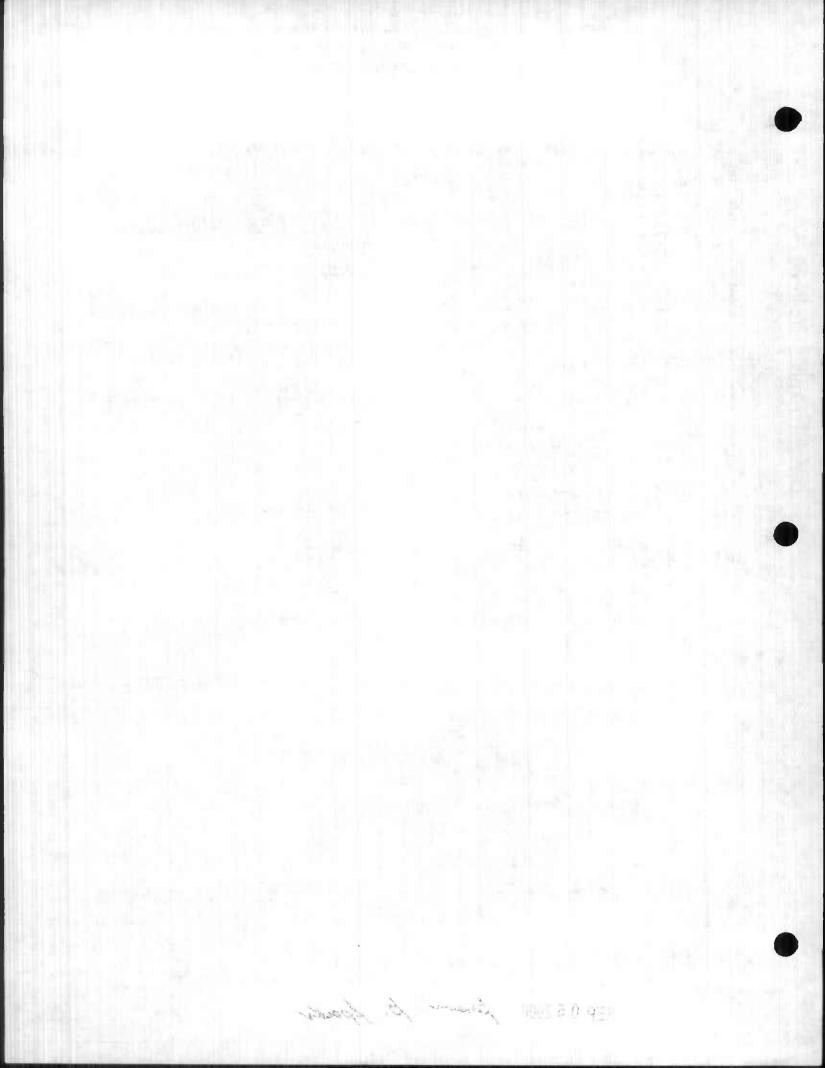
hysician	1. Decedent's Name (First, Middle, Li						2. Date of Do	BER 11,	Year	3. Time of Death		
/Medical	Justin Wayne	Shelton								17:22 P		
Examiner	4s Facility Nama (If not institution, gi					The same	or Location of Deal		y of Death			
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uneral rector		Sex 7. Age	(In yrs. last birthda 17 Yrs.	Months	Days		lin. 8. Date of Bi (Month, Di	ay, Year)	9. Binnpi Count Mary	ace (State or Fore ny) Land		
ž ==	10a. State 10b. County		10c. City, Town or	Location	7	-			10	od. Inside City Llm		
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r 28a-1	10e. Street and Number			10f. Zip	Code			10g. Citizen of	What Count	try?		
Par of	1705 C Crimson	Tree Way		21	040		FREE N	U.S.	Α.			
it, or teams 23s or 28s-1s.  Learner rount be nouried  by Funeral Director	11. Marital Status  1 12 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forcas? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		If Yes, special Yes		panic Origin? , Mexican, Pu Specify:	(Specify Yas or Nuarto Rican, etc.)		ica - America ack, Whita, e	otc.		
H, the Medical Completed	15. Decedent's E (Specify only highast gr Elementary/Secondary (0-12)	ducation ada completed) College (1-4or 5-	(Git		rk done du se retired)	tion uning most of	working	16b. Kind of E	Business/Ind	lustry		
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r la marked traumatic e	Gerald W. Shelt		405-345	Mar Addings			ica L. Ke		- State Tim	Codel		
in S	19a. Informant's Name/Reletionship Veronica L. Shel					n Tree	Rural Route Numi	gewood,		1040		
r other tr	20a. Method of Disposition	con (nounci	20b. Piece of Dis				Date	20c. Location				
- 0	1 Buriai 2 Cremation 3 4 Donation 5 Other (Speci		P A F	ematory or of	ther place,	Tnc	9/16/00	West C	hester	. PA		
injury	21. Signature of Funeral Service Lice									7 222		
D C C	Kirilen An	111/1/1	shap	Tarri	ng-Ca	argo Fu	neral Ho	me, P.A.				
	23a. Part 1. Enter the disease, or con shock, or heart feilure. List onty	onligations that caused	the death. Do not a				and 2100			Approximate		
niner	immediate Cause (Final disease or condition resulting in death)	a	MULTIP		JURI	ES.			 			
burial-transit	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury	b	Due to (or as a cons	equence of):				1				
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gned by the attendir be detached for use by Physician/A	Part II. Other aignificant conomiona	contributing to death bu	t not resulting in the	underlying c	ause givei	n in Part I.		Yee 2)80No				
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page 2							1 2	Pres 2 No	1)8	DYes 2□ No		
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al Director: After the lod in by the funera Certification:	27. Manner of Death  1 Naturat 5 Pending	28a. Dete of Injun (Month, Day	Year) injun	of P 2	28c. Injury Work		driver o	how injury occu	venici	ect was a e which st		
tor:	2 Accident investigation 3 Suicide 6 Could not l					as 2X No	a school		uper or Rusu	I Route Number		
in by	28e. Place of thjury - At home, farm, street, fectory, office building, etc. (Specify)								28f. Location (Street end N_niber or Rural Route Number City or Town, State) STEPNEY RD. NEAR RT. 22			
To the Funeral Directompletely filled in by Medical Certiff	29e. Certifier (Check only (Check only Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, dete and place, and the time, dete and place, and the time, determined in the time, determined i									ated.		
	and manner steled.  29b. Signature and title of cartifier 29c. License number								ned (Month, i	Dey, Year)		
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Comple	290. Signature and title of cartinar	IN	min.		0	CME		SEPTEN	BER 1	2. 2000		
To the Funeral Directo completely filled in by the Medical Certific	30. Name and address of person who	completed cause of de	MID.	e. Print)	0.0	C.M.E.	100 m	SEPTEM	BER 1	2, 2000		



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State of Maryland / Department of Health and Mental Hygiene 00 29401

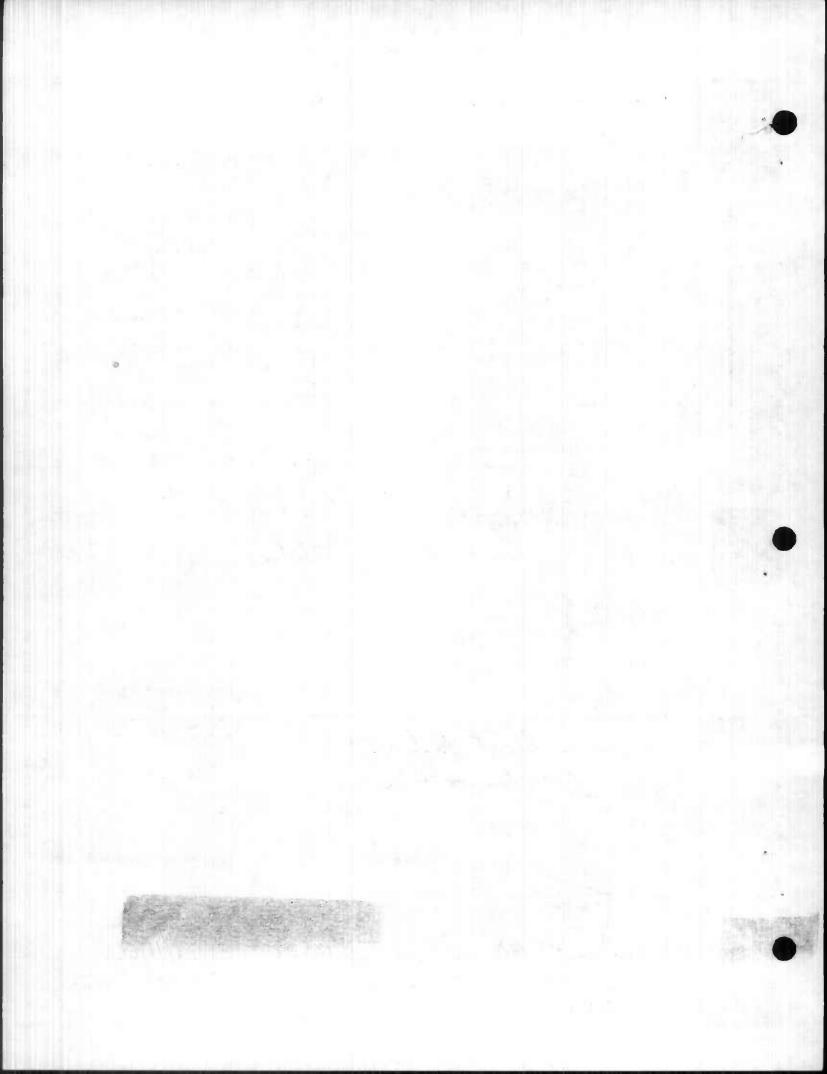
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State of Maryland / Department of Health and Mental Hygiene 0 29402

				C	ertifica	te of	Death		Reg. No.	0 6	9406
	1. Decedent's Name (First, I							2. Date of D		Year	3. Time of Death
Physician /Medical	Virgil Ja	ckson St	eward					Sept.	8 20	000	11:40 PM
Examiner	4a Facility Name (If not insti		i number)					n, or Location of Dea		ty of Death	
	2071 Corbe						Monk			imor	
Funeral Director	5. Social Security Number 571-36-6493		7. Age (In y	rs. last birthdi Yrs	Months	Days		Min. 8. Date of Bi	irth Year 919	9. Birth	place (State or Foreign ntry)
B	Usual Residence of Deceder 10a. State 10b. Co		10c.	City, Town or	Location					1	10d. Inside City Limits
vith the Maryla t or 28e-f show be notified at Director		timore	1 11	Monkt				3551	<u>B</u>		1 ☐ Yes 2 📈 No
6 2 4 10	10e. Street and Number 2071 Corbe	tt Rd.				p Code			U.S.A		ntry?
21215-0020 d within 72 hours after designer. If then "natural, or ferms The Medical Examiner in	11. Marital Status 1 □ Never Married 2亿 3 □ Widowed 4 □ Divo	Married 1 Y	Decedent Ever in d Forces? es 2 No , Give or Dates: WW		3. Was Deco			n? (Specify Yes or N Puerto Rican, etc.)	o- 14. Ra Bli Speci	ace - Americ ack, White, ity:	
21215-0 ed within 72 ho ygione. er than 'naturn f, the Medical.	15. Deci (Specify only h	edent's Education ighest grade complete	ed)	(G	cedent's Usi	ork done	during most of	of working	16b. Kind of I	Businass/In	dustry
T21	Elementary/Secondary (0-		ge (1-4or 5+)	- III	arper	use retire	id)	The state of	Lumbe	r Sa	105
	17. Father's Name (First, Mic	idle ( est)			arper	rcer		s Nama (First, Middle			105
Maryland 12 should be file h and Mental Hy T is marked other treumetic event	Walter J.							y L. Mil		unay	
Z sho	19a. Informant's Name/Rata				-			or Aural Routa Numi			
- 6994	Margaret E	. Steward		20			tt Rd	, Monkt			
Saltimore emit. Pages 14 hipariment of He important if Item ny Injury or oth files.	20a. Mathod of Disposition 1 🔀 Burial 2 🗆 Cremal 4 🗆 Donation 5 🗆 Other		om State	cemerary, o	malory or	other pla	) Cemeter	Sept. 12,	Phoen.		
Ball permit Depart Import any in	21: Signature M Funeral Ser	Sur Transport	t,		J.J.	Har	tenste	ein Mort	uary,I	nc.	7349
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Physician /Medical Examiner	Immediate Cause (Finat disease or condition resulting in dath)	a	200	celor	$\gamma_{l}m$	ulo	rolate	1		1 t	Onset and Death  Vens
ě	Toolsting in Guarry		Sue to	(or as a con	sequence of	):				1	
( 68760, rifficate be executed by physician and as the burial-transit.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		(or as a con							
A BE BE		d									
O. Box is death ce the attendit hed for use	Part II. Other significant con	ditiona contributing t	o death but not r	esulting in the	e underlying	cause gi	ven in Part I.	23b. Did	tobacco use c	ontribute t	o the cause of death?
that the de by the detached y Physic	ASCVD							10	Yes 2 No	3□ Pro	bably 4 Unknown
aw requires to been sign 2 should be	Congest	ve her	ant of	kule	ne				s an autopsy formed?	a\	Vere autopsy findings valiable prior to omplation of cause death?
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Of Vital I Physician: The this certificate real director, page: To Be Co	25. Was trase referred to me symptomer?	Hospital				10	har	d Death (Check only			
T all di	27. Manner et Death	1	□ Inpatient 2			OA		ing Home 5 19 Ass			(hy)
Affer funer funer	1 Natural 5 □ Pe	ending (A	ate of Injury Month, Day Year)	28b. Time Injur			nyat ork? ]Yes 2∐No		how injury occu	urred	
Division Attendent the death of the ctor: In by the artifical arti	2 Accidant investigation 3 Suicide 6 Could not be detarmined 28e. Place of tnjury - At homa, farm, street, factory, office 28f. Location (Street are building, atc. (Specify)								(Street and Num own, State)	nber or Aur	al Route Number,
Hospi 14 hou Funer fely fill		ifying Physician: To ical Examiner: On the									
To the Howithin 24 To the Fucomplete	29b. Signature and title of ce		TATHER SIGIOU.		25	c. Licen	se number		29d. Date nign	and /Month.	Day, Year)
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State	31. Date filed (Month, Day, X	1 8 2000 3	2. Registrarts Sig	nature	4	10	a. W.	11/10	/		



Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** Shepherd Grace L. 9:24 AM 9 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner **Allegany** Cumberland Memorial Hospital & Medical Center H Under 1 Year | H Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. F e B 3 , 1923 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) 6. Sex **Funeral** 10MXDF 77 218-16-2957 Yrs. Director Usual Residence of Decedent 10b. County r 28a-f show 10a. State 10c. City, Town or Location 10d. Inaide City Limits 1 ☐ Yes X ☐ No Mineral Ridgeley WV 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code Dir "natural", or flams 23s or the Medical Examiner must be Route 4 Box 2 26753 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes. 2 ☐ No If Yes, Give Yaar or Dates: Wes Decedent of Hispanic Origin? (Specify Yea or No-If Yea, specify Cuban, Mexican, Puarto Rican, etc.) Race - American Indien, Black, White, atc. 11 Merital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes ♣☐ No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Uaual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Department of Health and Alvertal Hy Important: If Hern 27 is mented other any injury or other tree 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Patrick A. Myers (Crabtree) Emma L 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Route 4 Box 2; Ridgeley WV 26753 19a. Informant's Name/Relationship (Type, Print) Robert K. Shepherd husband 20a. Melhod of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State X□ Buriel 2 □ Cremation 3 □ Removal from Stefe 4 ☐ Donation 5 ☐ Other (Specify) 9/10/ Cumberland, MD Sunset Memorial Park 21. Signaturated Funeral Service Licanses Scarpeldes of theral Home, P.A. Cumberland, MD 21502 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Betwe Onsat and Death **Physician** Immediete Cause (Final disease or condition resulting in death) /Medical . ACUTE MYOCARDIAL INFARCTION 1 DAY Examiner Due to (or as a consequenca of) Examine burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequenca of): Box 68760 edical Due to (or as e consequence of):

physician 4 attending 080 ō the detached 2 signed 8 peen page 2 has certificate

P.O.

Division of Vital Records.

218-16-2957

SHEPHERD

Physician/M à Completed or Attending Physician: Be 2 this Certification: After after death.

3 Sulcide

29b. Signature and

29a. Certifier one)

4 Homicide

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical 1 Yes 2 examiner? Hospital: 1 Compatient 2 ER/Outpatient 3 DOA Manner of Death 1 Avatural 2 Accident

5 Pending Investigation 6 Could not be determined

28b. Time of Injury

28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Injury et Work? 1 Yes 2 No

29c. License number

28c.

Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the causa(s) and manner as stated.

With dical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

100 33280

2000

29d. Date signed (Month, Day, Year)

21502

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

23b. Did tobacco use contribute to the cause of death?

3 Probably 4 Unknown

24b. Wera autopsy findings available prior to completion of cause of death?

1 ☐ Yea 2 ☐ No

20 No

1 Yes

24a. Was an autopsy performed?

1 Yes

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

26. Place of Death (Check only one)

mes

Registrar

edical

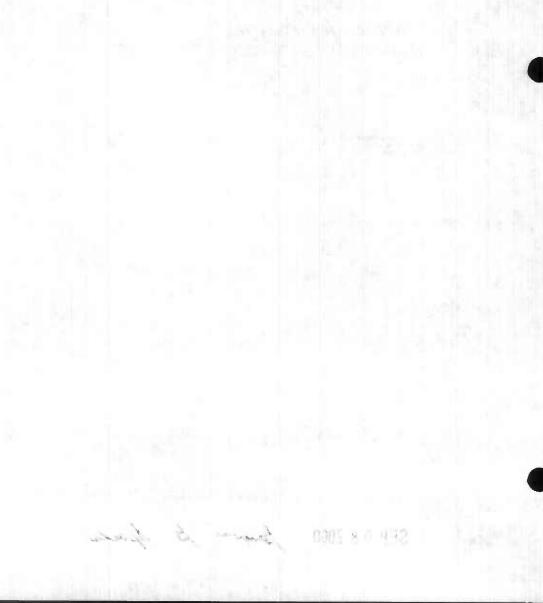
SUNIL GUPTA,

2. Registrar's Signatu

and manner stated.

JOHNSON HEIGHTS MEDICAL BLDG., CUMBERLAND, MD

To the Hospital o within 24 hours at To the Funeral Di



## Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** Tohn William Stewart AUG. 31 3:15 P.M. 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner Memorial Hospital & Medical Center Cumber land **Allegany** If Under 24 Hrs. 8. Date of Birth Hours Min Feb 5, 1912 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days XIOM 20F 217-10-4378 88 Vrs **Director** Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow traumedic event, the Medical Examiner must be notified at Yes 2□No MD Allegany Cumberland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 50 26 Wempe Drive 21502 USA 238 Funeral 12. Was Decedent Ever in U.S. Armed Forcas?
11 Yes 2 No
It Yes, Give V. II 14. Race - Amarican Indian, Black, White, etc. Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Herne 11. Marital Status e filed within 72 hours after al Hygiene. other than "natural", or lie 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 🌪 ☐ No Specify: white þ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Worker Yoders Plumbing 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fi Department of Health and Mental h Important: if Itam 27 is marked oft any injury or other traumatic evan obse. Be Russell Earl Stewart Bessie P (Miller) 19a. Intormant'a Neme/Relationship (Type, Print) RICK ROSS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11613 Hickory Avenue; Cumberland MD 21502 Nephew
20a Method of Disposition
4 Burial 2 Cremation 3 Removal from State 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Memorial Par9/02/ Cumberland, MD 21. Signature of Funaral Service Licensee Scarpedings of theral Home, P.A. Cumberland, MD 21502 ameo 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart tailure. List only one cause on each line. Approximata Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical ISCHEMIC CARDIOMYOPATHY 10 YEARS Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequenca of): burial-trar the attending physician and cata be exec 68760 Physician/Medicai that initieted events resulting in death) Last as the Due to (or as a consequence of): 0 23b. Did tobacco use contribute to the cause of death? should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yea 2 No 3 Probably 4 Unknown signed Division of Vital Records, P 24b. Were autopsy findings available prior to completion of causa of death? 24e. Was an autopsy Completed performed' director, page 2 this certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 No Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 27, Menner of Death Certification: 28d. Describe how injury occurred Injury at Work? After 5 Pending investigation 1 Natural 1 Yes 2 No death. 2 Accident 3 Suicide 6 Could not be determined 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) or A after 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D00145865 2000 trans James 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (6) DR.ROBUSTIANO J. BARRERA MEM.MED. BLDG. CUMBERLAND, MARYLAND 21502 32. Registrar's Signature

DHMH 16 Rev 6/95

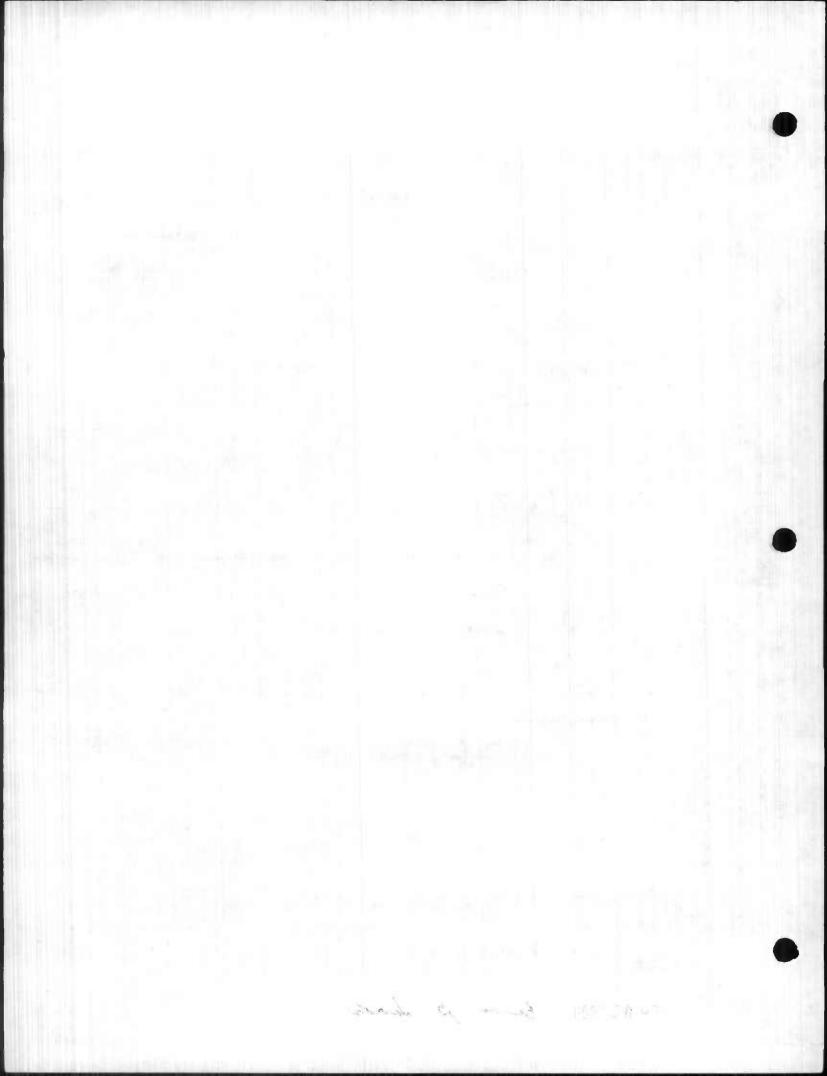
State Registrar

JOHN STEWART

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** LANA RAE SMITH SEPTEMBER 1 2000 13:17 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 24 Hrs. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) NOV 4 1949 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 10 M 2 F Months Hours 219-56-7595 50 Director MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 25a-f show must be notified at 1 Yes ZINO Director MARYLAND ALLEGANY MT. SAVAGE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number b 12310 MERRYWOOD ROAD 21545 Berns 23s U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② No 14. Race - American Indian, Black, White, etc. the same 1 Never Married 2 Married altimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Specify: WHITE À 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOME MAKER HOME MAKER and Mental Hygi point. Pages 1 and 2 should be file Department of Health and Americal Hyp Important: if hem 27 is medical Hyp any injury or 18. Mother's Neme (First, Middle, Maiden Sumame) 17 Father's Name (First Middle Last) Be FRANKLIN WESTFALL MARGARET LOUISE STARNS 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN BLAIR SMITH HUSBAND 12810 MERRYWOOD ROAD MT SAVAGE MARYLAND 21545 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete W Burial 2 ☐ Cremetion 3 ☐ Removal from State ROCKY GAP CEMETERY SEPT 5 2000 RFD FLINTSTONE MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Firmature of Funeral Service Licens 22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME P.A. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. enit Approximate tntervat Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) modera Examiner Examiner me Conges physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in death) Last Due to (or as e consequence of) Pulmorva dis Box 68760 Physician/Medicai Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. the á 1 Yes 2 No 3 Probably 4 Unknown signed t previdores P 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed has Yes 2□No 1 Yes 2□ No Division of Vital o Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certifica etaly filled in by the funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 20 ER/Outpatient 3 DOA 27. Menner of Death 28a. Date of tnjury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Hospital or within 24 hours after deaf To the Funeral Director 8 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) edical 29a, Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number arthy Pollen Je D 17565 SEPTEMBER 4 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nes DR ANTHONY J. BOLLING JR. 922 NATIONAL HIGHWAY LAVALE, MARYLAND 21502 SEP 0 5 2000 32. Registrar's Signature Registrar



1. Decedent's Name (First, Middle,	I eet)		Certificate of	of Death	2. Date of De	Reg. No.	3. Time of Death
ian Royce Art					Month	Day	7:40PM
4a Facility Name (If not institution,				4b. City, Town,	Sept or Location of Death	-	
Memorial Ho				Cumberl	and	Alle	gany
5. Social Security Number 214-07-2571 Usuel Rasidenca of Decedent	3. Sex 1 1 M 2 F 7. Age	83	Yrs. If Under 1 Ye Months De		8. Date of Bin (Month, Da Nov. 2		Birthplace (State or Foreign Country)     MARYLAND
10a. State 10b. County WV MINE	RAL	10c. City, Tow RIDGI					10d. Inside City Limits 1 ☐ Yes 2∑ No
10e. Street and Number ROUTE 2, DIRTY 1	FOOT ROAD		10f. Zip Cod 267.			U.S.A	
11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? d 1 12 Yes 2 1 N If Yes, Give 1 Year or Detes:	lo	13. Was Decedent If Yes, specify C		(Specify Yes or No erto Rican, etc.)	- 14. Rac Blac Specify	e · American Indian, ck, White, atc.  WHITE
15. Decedent's (Specify only highest Elamantary/Secondary (0-12) 12		.)	Decedent's Usual Oc (Give kind of work do life. DO NOT use ra NSTRUMENT	ne during most of tired)	900		usinass/Industry IY BALLISTICS ORY
17. Fether's Neme (First, Middle, LI CHARLES E. SMELS					Name (First, Middla, IA JANE CF		ne)
19a. Informant's Name/Relationshi			b. Meiling Address (Str				
WILLYS L. SMELSI  20a. Method of Disposition  1 ♀ Buriei 2 □ Cremetion 3		20b. Pleca o cemete	1612 ASPEN of Disposition (Name only, crematory or other	f place)	9/5/2000	20c. Location	City or Town, State
4 □ Donation 5 □ Other (Special Service Li		SUNSET!	22. Name and Ad UPCHURCH	Idress of Facility	HOME, P.		LAND, MD
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23a. Part1. Enter the dispase, or c shock, or heart feilure. List or limmediete Cause (Final disease or condition	nly one cause on each lin	10.	202 GREE not antar the mode of	CNE ST., dying, such es card	CUMBERLAN diac or raspiratory a	D. MD 2	Approximate Interval Batween Onset and Death
shock, or heart feilure. List or Immediate Cause (Final	Arterio:	sclerot	202 GREE	CNE ST., dying, such es card	CUMBERLAN diac or raspiratory a	D. MD 2	Approximate Interval Batween Onset and Death
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DHMH 16 Rev 6/95

Registrar

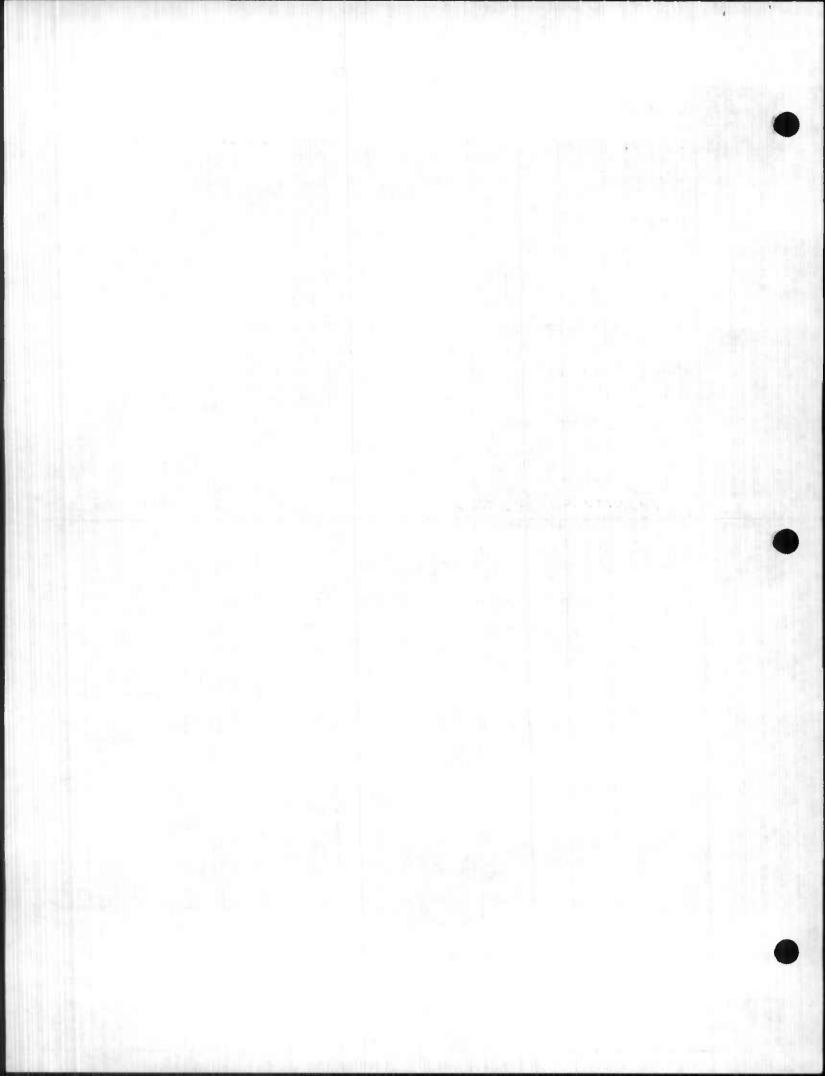
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State of Maryland / Department of Health and Mental Hygiene

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No.							

To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  DELAWARE  KENT  10a. Street and Number  2689 JUDITH ROAD  11. Marital Status  1 Nevar Married  15. Decedent's  (Specify only highest Elementary/Secondary (0-12)  12  17. Father's Nama (First, Middla, La  RAYMOND EDWARD	NS HOSPITAL  Sex 1 M 2 F  12. Was Decedent Armed Forces? 1 Myes 2 H Yes, Give Year or Dates:	64  10c. City, 1  HART	Yrs.  Fown or Loc  LY	If Unde Months cation	I Year Days	BALTIM	ORE 24 Hrs. Min.	2. Date of De Month Augustation of Death CITY  8. Date of Bir (Month, De O1-17-	Day 30 4c. Count BALT	9. Birthp Cour KENTI	olace (Stetchtry)	ot Death
To Be Completed by Funeral Director	THE JOHNS HOPKI  5. Social Security Number  221-22-6887  Usual Residence of Decedent  10a. State  10b. County  DELAWARE  KENT  10a. Street and Number  2689 JUDITH ROAI  11. Marital Status  1 Nevar Married  15. Decedent's  (Specify only highest status)  Elementary/Secondary (0-12)  12  17. Father's Nama (First, Middla, La RAYMOND EDWARD	NS HOSPITAL  Sex  1 X M 2 F  12 Was Decedent Armed Forces? 1 X Yes 2 I If Yes, Give Year or Dates:  Education greda complated)	64  10c. City, T  HART  Ever in U,S.	Yrs.  Fown or Loc  LY	If Unde Months cation	I Year Days	4b. City, Tow BALTIM If Under 2	ORE 24 Hrs. Min.	CITY  8. Date of Bir (Month, De	H 30 4c. Count BALT	y of Death  IMORE  9. Birthp Cour  KENTI	place (Stete	
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To Be	RAYMOND EDWARD	0	E	TEATIN	NG &	AIR	CONDI			H&S		CES	
										, Maiden Suma	me)		
		SCHANDING							WILLIS				
-	19a. tnformant's Name/Relationship									er, City or Town			
2	MILDRED A. LUDW	IDK PAYNE S					TH ROA	D, H					
	20a. Mathod of Disposition  1 By Burial 2 Cremation 3 4 Donation 5 Other (Spe		cem	e of Dispose etery, crem RON HI	ILL N	other ple	RTAT.	9-05	Date -2000	DOVER,			
-	21. Signature of Funeral Service Lie	censee	/	22.	. Name a	ER FU	ss of Facility	HOM	E INC.	DELAWAR			
	23a. Part1. Enter the disease, or co shock, or heart failure. List or	emplications that caused	d the death.								LIJJ	Approxim Interval E	nate
	SHOCK, OF HEART FAILURE. CIST OF	ny oria causa ori each in	*1Q.									Onset an	
	Immediate Cause (Final disease or condition	Pn	Cumo	custi	is c	avi	nii m	1844	maica			lin	onth
	resulting In death)	8.	Due to (or a	s a consequ	quenca of)	:	1.	0000	COVITO				
Examiner		- IWI	Muno	- cow	APVO	mi	se					3 m	ears
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	Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury	e W	eque	15 91	vanu	loun	atus is	2				24	ears
Medic	that initiated events rasulting in death) Last	• d	Due to (or as	s a consequ	uenca of):							1	
Physician/	Part II. Other significant conditions	contributing to death b	out not resultin	ng in the ur	nderlying	cause giv	ven in Part I.		23b. Dld	tobacco use c	ontributs t	o the caus	se of death'
									10	Yes 2 No	3 Pro	bably 4	Unknow
Completed by										s an autopsy ormed?	av cc	ere autops vailable pri ompletion of death?	
5									1月3	Yes 2 No	1	☐ Yes 2	No
	25. Was case referred to medical		VIII II I				26. Place	of Deat	(Check only	one)			
10	examiner? 1 Yes 2 XNo	Hospital:	ent 2 EF	Q/Outpatien	nt 3 D	OA OII	ner: 4 Nu	rsing Ho	me 5 Res	idence 6 🗆 O	ther (Speci	fy)	
	27. Manner of Death 1 Anatural 5 Pending 2 Accident Invastiga	28a. Date of Inju (Month, Da	iry 28	8b. Time of Injury	M	28c. Inju Wo 1 🗆	ryat rk? IYes 2 □ l		28d. Describe	how injury occu	irred		
Certification:	3 Suicide 6 Could no determin	200. FINDE OF ITT	jury - At home c. (Specify)	e, farm, stre	eet, facto	ry, offica				(Street and Num wn, State)	ber or Run	el Routa N	lum <i>ber</i> ,
		Physician: To the best aminer: On the basis of and manner st	f examination										e(s)
-	29b. Signatura and title of certifiar				29	c. Licens	se number			29d. Date sign			
	I Linde adle	ymp				PE	5-00	00		Septemb	w 12	2000	)
3	1.6		death (Item 2:	- 1 -		9-							
tate 3	30. Nama and address of person w Linda Adler, Mp 60	ON. Wolfe St	. Nel	3a) (Type, I	Print)	llin	core, 1	no	21287	-9106			



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Year J. STOUALL SEPTEMBER 7, 2000 8:40 AM MARGARET 4e Facility Nama (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death YORTHWEST HOSPITAL CENTER CAMPALLSTain BALTIMORE If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) Months Days 1 ☐ M 2 🕮 F 512 22 6751 78 Jan 4, Oklahoma Usual Rasidance of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 XNo Pender Hampstead 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 344 South Belvedere Drive 28443 United States 12. Was Decedent Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 1 ☐ Yes 2 ☒ No If Yas, Giva Yaar or Datas: 1 Nevar Married 20 Merried 1 ☐ Yes 2 ☑ No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Hame 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Press R. Harris Queenia Butts 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack P. Stovall/Husband 344 South Belvedere Drive Hampstead, NC 28443 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Dete 20c. Location - City or Town, Stata Burial 2 Cremation 3 Removel from Stete 4 ☐ Donetion 5 ☐ Othar (Specify) Sea Lawn Memorial Park 9-14-2000 Hampstead, NC 22. Nama and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 21. Signatura of Funeral Service Licensea m01044 a 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert feilure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediata Cause (Finel ACUTE MYOCARDINE INFARCTION 2 HOURS disaasa or condition rasulting in daath) CORON AMY ANT 10 YEARS Sequentially list conditions, if any, laading to immadiete cause. Entar Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? PLA CEMENT 1995 STENT 24b. Were autopsy findings available prior to completion of cause of death? HONTIC VALUE PROSTIESIS 24a. Was an autopsy FRION CORONARY ARTERY BYPASS GRAPTS 1 Yas 2 No 1 ☐ Yas 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of 5 Pending Invastigation 1 Natural Accident 1 ☐ Yes 2 ☐ No 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide

Physician/Medical by Be Completed

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**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

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Department of Important: If any injury or

**Physician** /Medical

Examiner

filed within 72 hours after

21215-0020

Baltimore, Maryland

Box 68760.

P.O.

Records,

Division of Vitai

Director

by

Completed

or Attending within 24 hours after death. To the Funeral Director: A Hospital

Medical completely the th 10 04/010

25. Was casa rafarred to medical examiner?

1 Yes 2 No 27. Mannar of Death

29e. Certifier

(Check only one)

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated.

29b. Signatura and titla of certifiar

31. Data filed (Month, Day, Year)

29c. License number

29d. Data signed (Month, Day, Year) SEPTEMBER 7, 2000

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

MO

OLD COURT ROAD MO KOBERT 5401

RANDAUSTOWN MD 21133

Registrar

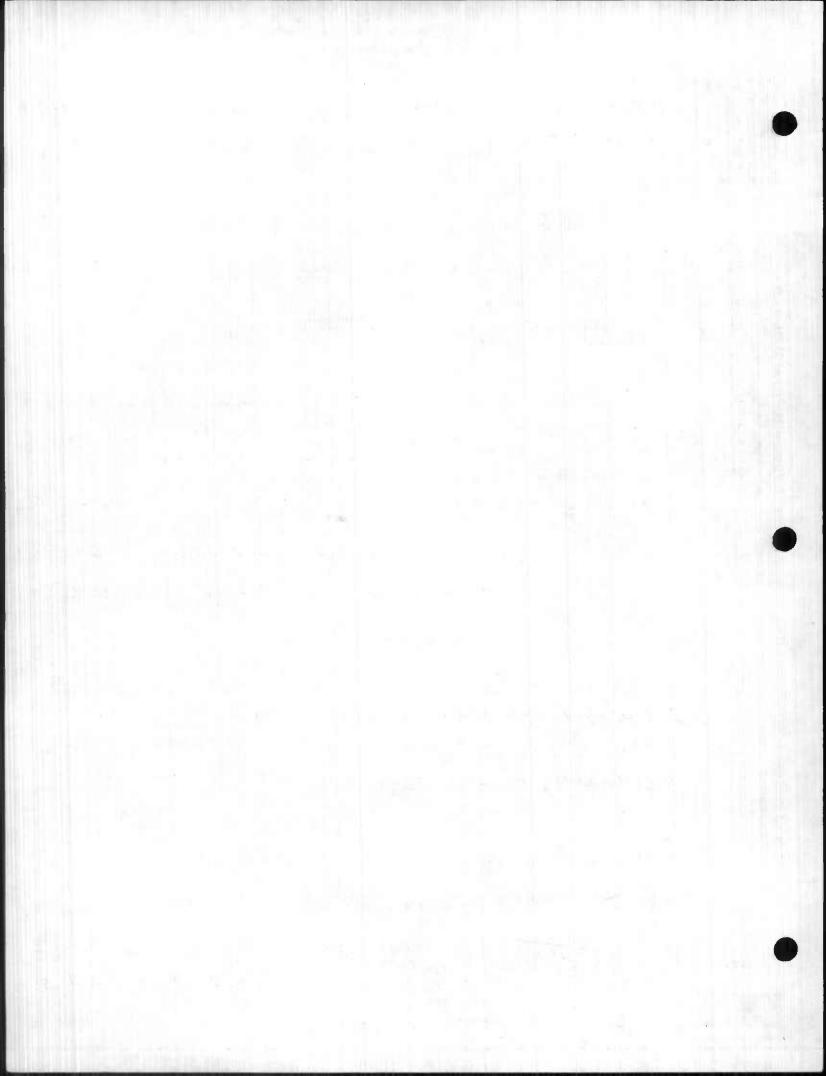
SEP 1 1 2000

32. Registrar's Signatura

**ORIGINAL** 

State

**DHMH 16 Ray 6/95** 



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month 3, **Physician** Martin 2000 10:30pm Walter Sep /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, give street end number) Examiner Cumberland Allegany Allegany County Nursing Home 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Deys. Hours Mig. (Month, Deys. Year) 1909 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** ¥DM 2□F 217-10-4277 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 le marked other than "naturel", or Items 23a or 28a-f ehow treumstic event, the Modical Examiner must be notified at Y□Yes 2□No Director Allegany Cumberland MD 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 21502 USA 514 Cumberland Street Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes - 2 ☐ No If Yes, Give Year or Detes: 14. Race - American Indien, Black, White, etc. 72 hours efter 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specimite by X□ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filled within 72 l Depertment of Health and Mental Hyglene. Important: if Item 27 le marked other than "natu any Injury or other treumatic event, the Modical DDCs. 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Retired Chemist Textile 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) (McGeady) Michael Martin Margaret 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
304 Cumberland Street; Cumberland, MD21502 19a. Informant's Name/Reletionship (Type, Print) Kathy McGann daughter disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State W Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SS Peter Paul Cemetery9/08/ Cumberland, MD 21. Signature of Funeral Service Licanses Scarped Address Fulleral Home P.A. Cumberland, Maryland 21502 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical a COROPARY ARTORY DISEASE 5 YKS Examiner Due to (or as a consequence of): Examiner that the death certificate be executed ettending physicien end for use es the bunel-fransi Sequentially ilst conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es a consequence of): signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 3 □ Probably 4 □ Unknown 1 Yss 2 No CARCINOUN OF THE VEOSTATE þ 24b. Were autopsy findings available prior to Completed 24e. Wes en autopsy periormed? peed completion of ceuse of death? page 2 s 990 The 1 ☐ Yes 2 No 1 Yes 2 No certificate After this certifice funeral director, Be 25. Was case referred to medicel axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

or Attending Physicien: death. 24 hours efter deat Funeral Director: filled in by Hospital

within 2

My &

Registrar

Robustiano J. 31. Date filed (Month, Dey, Year) SEP 0 7 2000

duy

30. Name end address of person who completed ceuse of deeth (Item 23e) (Type, Print)

29b. Signature and title of optifier

4 Homicide

(Check only one)

29a. Certifier

edical

Barrera M.D. Mem. Hosp Med Bldg Cumberland MD 21502 32. Registrar's Signature

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

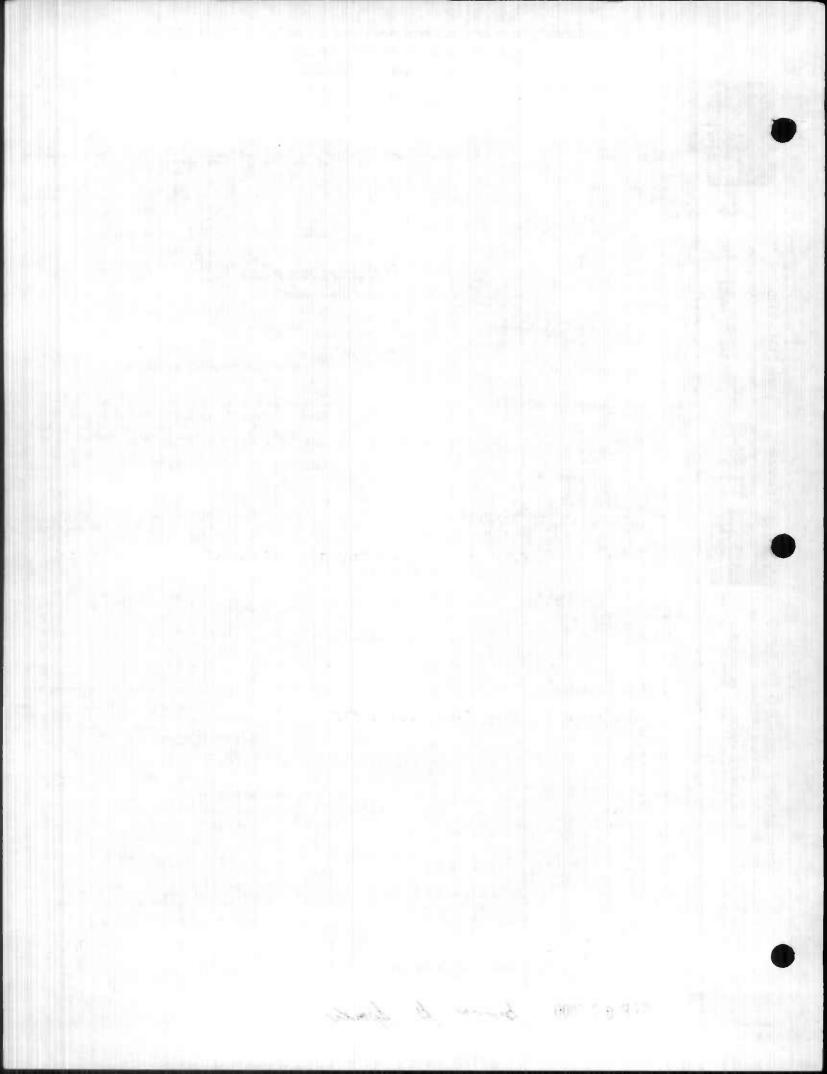
book

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and menner stated.

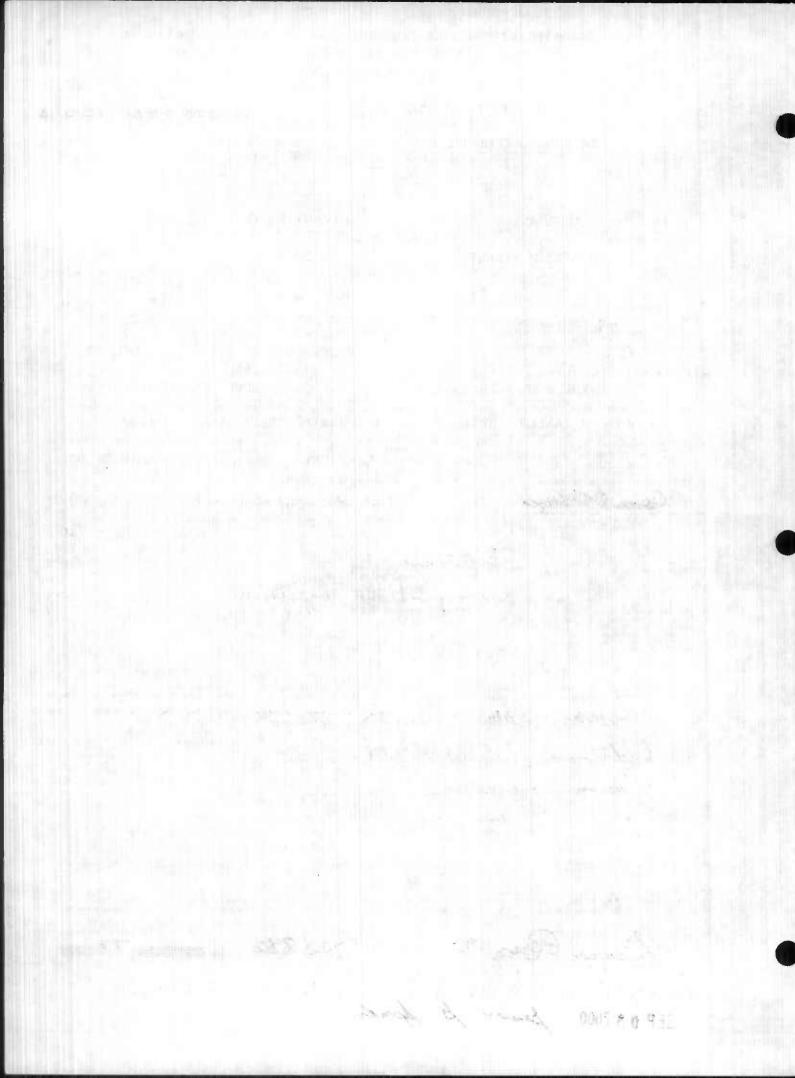
29c. License number

29d. Date signed (Month, Dey, Year)



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The informant's Name/Frestionating (Type, Print)  CAROLYN M. TAXLOR WIFE  106. Melling Address (Sinet and Namber or Paral Route Number, City or Town, Sais, Zip Code)  CAROLYN M. TAXLOR WIFE  106. Melling Address (Sinet and Namber or Paral Route Number, City or Town, Sais, Zip Code)  CAROLYN M. TAXLOR WIFE  106. Melling Address (Sinet and Namber or Paral Route Number, City or Town, Sais, Zip Code)  CAROLYN M. TAXLOR  WIFE  106. Melling Address (Sinet and Namber or Paral Route Number, City or Town, Sais, Zip Code)  CAROLYN M. TAXLOR  WIFE  106. Melling Address (Sinet and Namber or Paral Route Number, City or Town, Sais, Zip Code)  CAROLYN M. TAXLOR  WIFE  107. Melling Address (Sinet and Namber or Paral Route Number, City or Town, Sais, Zip Code)  CAROLYN M. TAXLOR  WIFE  108. Melling Address (Sinet and Namber or Paral Route Number, City or Town, Sais, Zip Code)  109. Melling Address (Sinet and Namber or Paral Route Number, City or Town, Sais, Zip Code)  109. Melling Address (Sinet and Namber or Paral Route Number, City or Town, Sais, Zip Code)  109. Melling Address (Sinet and Namber or Paral Route Number, City or Town, Sais, Zip Code)  109. Melling Address (Sinet and Namber or Paral Route Number, City or Town, Sais, Zip Code)  108. Melling Address (Sinet and Namber or Paral Route Number, City or Town, Sais, Zip Code)  109. Melling Address (Sinet and Namber or Paral Route Number, City or Town, Sais, Zip Code)  109. Melling Address (Sinet and Namber or Paral Route Number, City or Town, Sais, Zip Code)  109. Melling Address (Sinet and Namber or Paral Route Number, City or Town, Sais, Zip Code)  118. Melling Address (Sinet and Namber or Paral Route Number, City or Town, Sais, Zip Code)  129. Sequentially Address (Sinet and Namber or Paral Route Number, City or Town, Sais, Zip Code)  120. Melling Address (Sinet and Namber or Paral Route Number, City or Town, Sais, Zip Code)  121. Melling Address (Sinet and Namber or Paral Route Number, City or Town, Sais)  1228. Deal of General Route Number, City City Sain, Sain, Sain	D MAN O		Last)					18. Moth	er's Nam	e (First, Middle	. Maiden Sumer	na)	
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24a. Was an autopsy performed?  24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death (Check only one)  1   Yes   2D No   2D No   2	- 0 0 0	Part It. Other significant condit	ona contributing to de	ath but not reaulting	in tha u	nderlying o	eusa giv	en in Part	1.	23b. Dld	tobacco uss co	ontribute t	to the cause of death?
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29a. Cartifler (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner es stated.  29b. Signature and title of certifier  29c. Licansa number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of daath (Itam 23e) (Type, Print)  Control By 22 M.D. 112 Staten Drue Cumber and MD 21502  State  31. Date filled (Month, Day, Year)  32. Registrar's Signsture	After fune		28a. Date o		. Time of	4 2	28c. Injur Wor	y at k?					
29a. Cartifler (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner es stated.  29b. Signature and title of certifier  29c. Licansa number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of daath (Itam 23e) (Type, Print)  Control By 22 M.D. 112 Staten Drue Cumber and MD 21502  State  31. Date filled (Month, Day, Year)  32. Registrar's Signsture	Oivisi or Atten after deal Director: In by the	3 Suicide 6 Could 4 Homicide	not be 28e. Piece	of Injury - At home, ag, etc. (Specify)	farm, str	reet, factor	y, office			28f. Location City or To	(Street and Num iwn, State)	ber or Rur	ral Route Number,
30. Name and address of person who completed cause of daath (Itam 23e) (Type, Print)  George Brezg M. D. 912 Seton Drive Cumberland MD 21502  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature formula	Hospital 24 hours Funeral etely filled Clical C.		Examiner: On the bar	sis of examination a									
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State 31. Date filed Month, Day, Year) 1 32. Registrar's Significant from the Cumberland MD 21502	5	30. Name and address of no.	who completed as:	of death /ltom 22-	) (Tunn	Print)	~	10			SETTEMB	EK	7 2000
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Registrar SED (1 X / 1)		31. Date filed (Month, Day, Year SED o R 2000	32. Re	gistrar's Signature	do	orto	1		22112				



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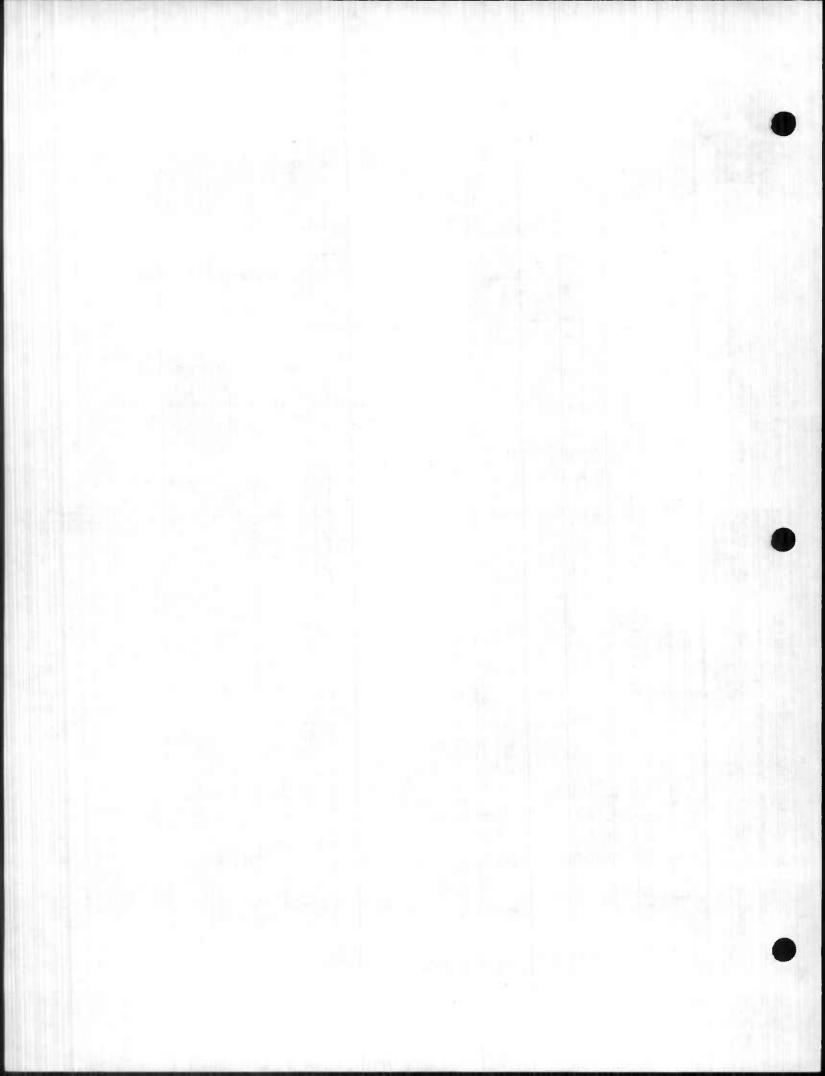
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Jack Carlton Tebay Sept. 6 2000 9:27 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince George's If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys Hours 10XM 20 F Months 233-46-8459 Director 68 Nov. 19, 1931 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 28a-f show 1 Yes 2 No must be notified Director Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Name 23a or 9304 Montpelier Drive 20708 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever In U.S. Armed Forces? 14. Race - American Indien, Black, White, etc. permit. Pages 1 and 2 should be illed within 72 hours shar Department of Health and Mental Hybjano. Department of Health and Mental Hybjano. Inspirately, or les importants if item 37 is marked other than "natural, or les any injury or other trausmette event, the Medical Examples any injury or other trausmette event, the Medical Examples 1 Yes MYNo If Yes, Give Yeer or Detes: 1 Never Married 2 Merried 1 Yes 2 No 21215-0020 Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Engineer NASA Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Lloyd Scott Tebay Helen L. Logston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Joan Tebay/Wife 9304 Montpelier Drive, Laurel, MD 20708 Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 9/11/00 Catonsville, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licenses 313 Talbott Avenue, Laurel, MD 20707 M00773 or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Ceuse (Final Anterior Wall Myocardial Infarction 30 Hours disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Examiner The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) and Box 68760. attending physician Physician/Medical tha Due to (or as e consequenca of) signed by the aid be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1XX aa 2 No 3 Probably 4 Unknown Hyperlipidemia Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2XXNo 1 ☐ Yes 2XXVo or Attanding Physician: 25. Was case reterred to medical examiner?
1 ☐ Yes XXNo Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Reaidence 8 Other (Specify) Certification: To 1 X Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28d. Describe how Injury occurred 28a. Date of Injury (Month, Dey Year) 28b Time of 28c. Injury at Work? 5 Pending investigation To the Hospital or Attandin within 24 hours after death. To the Funeral Director; Af 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, atreet, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 157 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edicai (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie D26443 September 7,2000 ce m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15225 Shady Grove Road, Rockville, MARYLAND 20850 Fisher GREGORY 11 31. Detectifed (Month, Dey, Year) SEP 1 2000 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

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**ORIGINAL** 

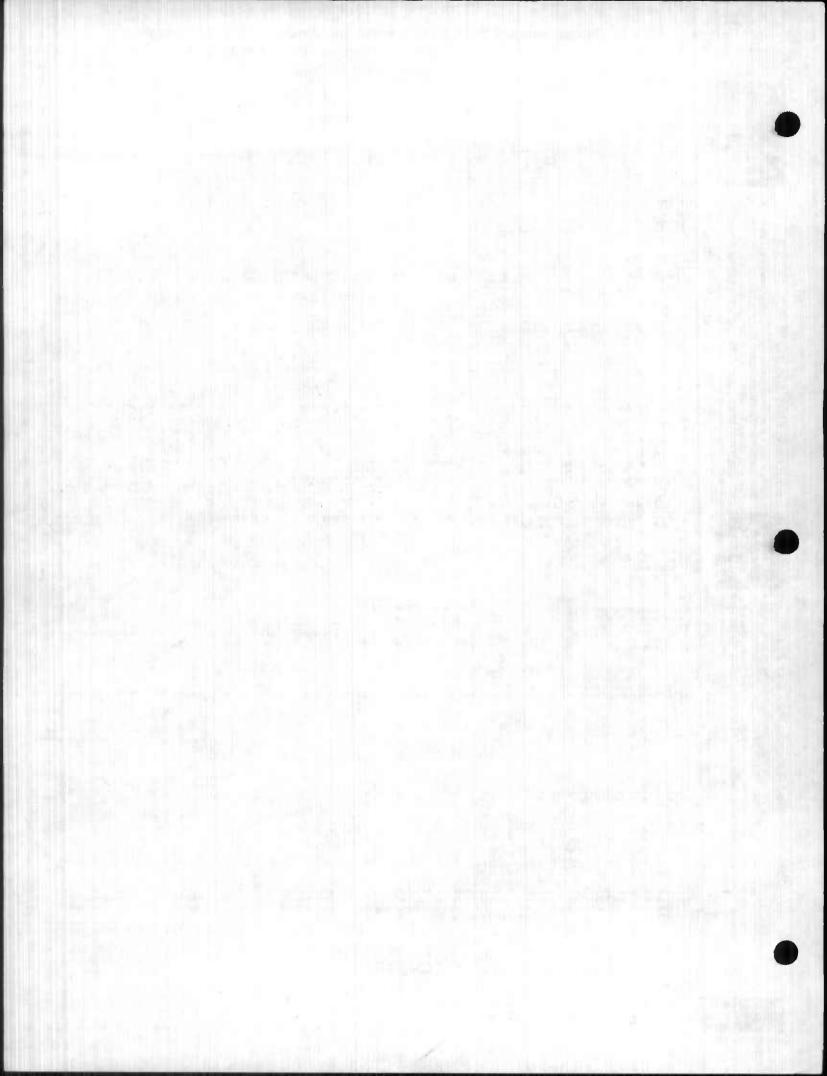


00-5040-027 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. B.K.S amend item 23a,27,28a,b,c,d,e,f per State of Maryland / Department of Health and Mental Hygiene IRAN CHAUCER THWEATT me G787 9/25/00 vf Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Death **Physician** IRAN CHAUCER THWEATT 4, 2000 SEPT. 11:47 AM '/Medical 4a Fecitity Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD 5963 HARPERS FARM ROAD APT. #5 COLUMBIA 5. Social Security Number If Under 1 Yeer | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Days Hours 11 M 2□ F Yrs. 076-60-3489 26 Director Jan 19, 1974 New York Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Howard Columbia "natural", or Nerse 23s or 25s-f than "natural", or items 23s or 25s-f the Medical Examiner must be notified 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7462 Sea Change United States 21045 Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Merried 2 ☐ Married Maryland 21215-0020 1 Yes 2 No Specify. Specify à 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Computer Technician Community College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Montal is marked David Thweatt Ingrid Carmichael 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 a artment of Health a present: If them 27 is Ingrid Carmichael-Thweatt/Mother 7462 Sea Change Columbia, Maryland 21045 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date Pages hant of h 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 9-6-2000 Catonsville, MD 21 Signature of Funerel Service Licenses 201044 22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. ma 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** tmmediate Cause (Final disease or condition resulting in death) /Medical a. INTRA-ORAL GUNSHOT WOUND Examiner Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be execu Box 68760, the attending physician Physician/Medical Due to (or as a consequence of) as the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contributs to the cause of death? 3 1 Yas 2 No 3 Probably 4 Unknown should be det Division of Vital Records, by 24b. Were autopsy findings Completed 24a. Was an autopsy available prior to completion of cause of death? parformed page 2 1XYes 2 No 1 Yes 2 No this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) AT SCENE 2 1 Yes 2 No 28a. Date of Injury found: (Month, Day Year) 9/4/00 28d. Describe how injury occurred subject shot self 27. Manner of Death 28b. Tima of 28c. tnjury at Work? Certification: After Attanding 1 Natural 5 Pending investigation unknown 1 Yes 2 XXVo 2 Accident Director: / 6 Could not be 3 Quicide 281 Location (Street and Number or Rural Route Number, City or Town, State) 5963 Harpers Ferry Roa Apt. 5, Columbia, Howard County, MD 28e. Placa of Injury - At home, larm, street, factory, office building, etc. (Specify) found: home yd ni bellii after a 4 Homicide To the Hospital
within 24 hours a
To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

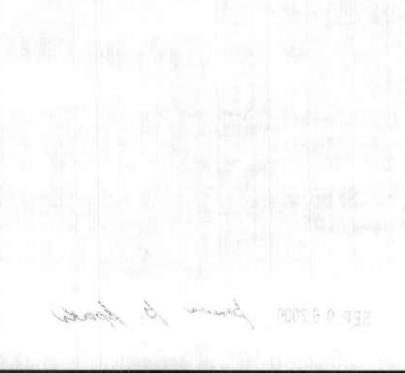
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number O.C.M.E SEPT. 5, 2000 M.Di 30. Name and address of person who completed cause of death Hem 23a) (Type, Print) Radentz phen 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) SEP 1 1 2000 32. Registrar's Signature State

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Registrar



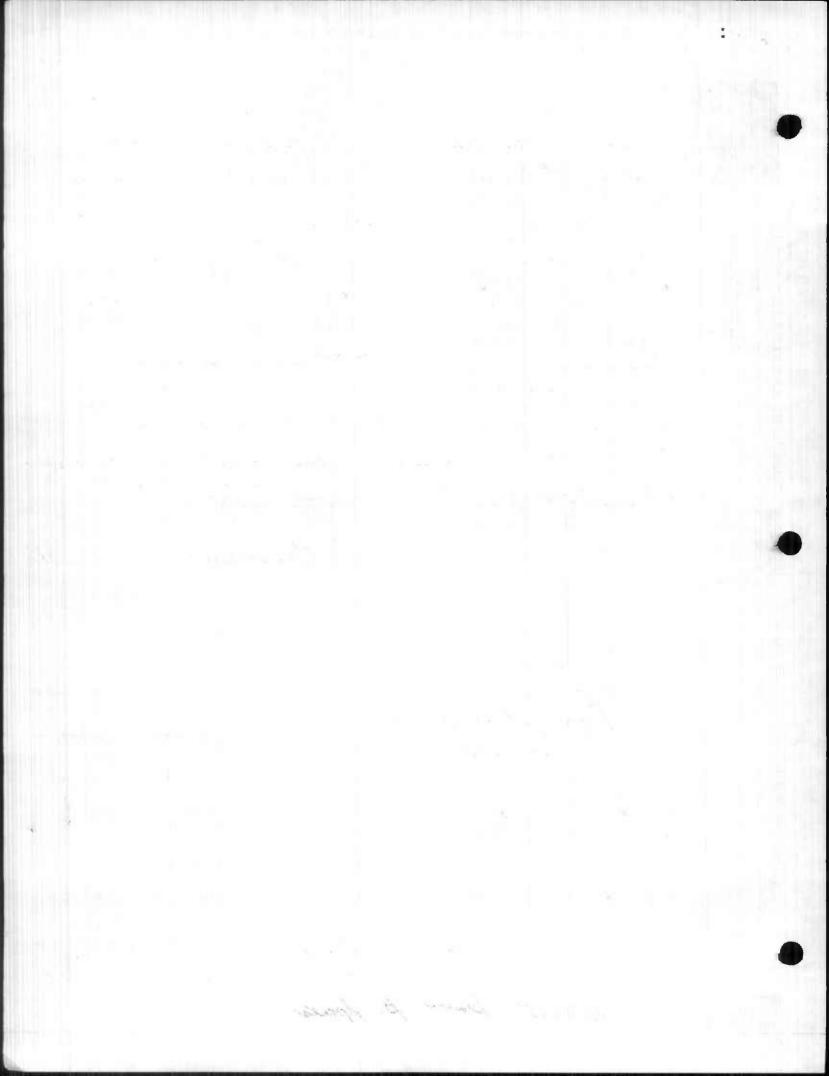
hysician		2. Date of Dec Month	Dey	3. Time of Death
/Medical xaminer	An City Court or I care institution give street and number)	ocation of Death		of Death
neral ector	5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Dete of Birt (Month, Da MARCH	th y, Year) 20,1933	Birthplace (State or Foreign Country)     MARYLAND
0.0	Usuat Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d, Inside City Limits
tor				1 ☐ Yes 2 1 No
Directo	10e. Street and Number 10f. Zip Code		10g. Citizen of W	That Country?
Funeral		necify Yes or No	USA 14 Bace	a - American Indian,
20	3 ☐ Wildowed 4 ☐ Divorced Year or Dates:	o Rican, etc.)	Specify.	k, White, etc.
eted	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	king	16b. Kind of Bu	siness/Industry
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Be C		ne (First, Middle,		
To	EDWARD KIMMEY MINNIE	WILLING		
	19e. informant's Name/Reletionship (Type, Print)  SETH B. WHEATLEY/HUSBAND  RT. 3, BOX 286E, SEAF			
	20e. Method of Disposition 20b. Place of Disposition (Name of	Date		City or Town, Stete
		9/7/00	GALESTO	WN, MARYLAND
9000	21. Signature of Funeral Service Lymnes 22. Name and Address of Fecility ZELLER FUNERAL HOM 106 MAIN STREET, E			
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/ Physicia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did	tobacco use cor	ntributs to the cause of death?
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d in by th	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location ( City or To	Street and Numb wn, State)	er or Rural Route Number,
completely filled in by the funeral Medical Certification:	29e. Certifier  1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece (Check only one)  2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and plece and manner stated.	e, and due to the arred et the time,	cause(s) end ma date and plece,	nner es stated. and due to the cause(s)
completely filled in the Medical Certi	29b Signature and this of certifier 29c. License number AU417 G35 [2	2446		d (Month, Day, Year)
	30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)  8 ABAK. MOE in olmoth, 22 South green St  31. Determine the (Month, Day, Year)  SEP 0 6 2000  32. Registrar's Signature  6. Spacks	QALL	~	M.D 2 12 1
	BABAK. MosiNolyolki 22 Josh freen St	1 136414		1 1 / / / / /



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State of Maryland / Department of Health and Mental Hygiene 29414

Physicia-	Decedent's Neme (First, Middle,						2. Dete of Dee Month	th Dey	Yeer	3. Time of Deeth	
Physician /Medicai	WI	LLIAM	FIRTH	WEIL	LS			28 200		1:00 p.m	
Examiner	4e. Fecility Neme (If not Institution, g	give street and nur	m <i>ber)</i>			4b. City, Town, or Lo	ocation of Deeth	4c. County	of Deeth		
	Dorchester	General	Hospita	1		Cambr	idge	Do	chest	er	
ineral rector	579-36-9429	Sex 1MM 2□ F	7. Age (In yrs. la:	st birthday) Yrs.	If Under 1 Year Months Deys		8. Dete of Birth (Month, Day April 1	Year) 1916	9. Birthple Countr Delay	ece (State or Foreig y) vare	
12	Usuel Residence of Decedent  10a. Stete 10b. County		10c. City,	Town or Loc	cation				10	d. Inside City Limits	
Director	MD Dorc	hester			Cambri	dge				1 Yes 2 □ No	
Dire	10e. Street end Number				10f. Zip Code		1	0g. Citizen of	What Countr	ry?	
2	520 Glenburn					21613		U.S.A.			
by Funeral Di	11. Merital Status  1 ★ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Fo	2 <b>K</b> No		Vas Decedent of Yes, specify Cul ☐ Yes 2 No	Hispenic Origin? (Sp ben, Mexicen, Puerto Specify:	ecify Yes or No- Ricen, etc.)		ce - America ck, White, e	tc.	
Completed	15. Decedent's (Specify only highest of	grade completed)	Acr S.	16a. Deced (Give I life. D	ent's Usuel Occu kind of work done OO NOT use retire	petion a during most of work ad)	ring	16b. Kind of B	usiness/indu	ustry	
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ian ical ner	23a. Pert1. Enter the disease, or co shock, or heert feilure. List on Immediete Ceuse (Final disease or condition resulting in deeth)	mplicetions that c ify one cause on e	ech line.	Do not ente		0	or respiretory err			Approximate Intervel Between Onset end Death	
fedical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest	c		es e conseques e consequ							
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detached for use as Physician/Me	Pert II. Other significent conditions	contributing to de	eth but not result	ing in the un	derlying cause g	iven in Pert I.	23b. Dld to	bacco usa co		the cause of death	
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director, page							1 🗆 Y	es 2 No	1 🗆	Yes 2□ No	
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-	1 Yes 2 No			R/Outpetlen	3LI DOA		ome 5 Resid			)	
completely filled in by the funera Medical Certification:								28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number			
completely filled in by the funer	4 ☐ Homicide determine	buildii	ng, etc. (Specify)	10, tailii, Siit	et, rectory, office		City or Town		oor or ridial	rioure ivalidar,	
mpletely fill	29a. Certifier (Check only one) 1 Certifying 1	aminer: On the be	best of my knowledges of exeminetion of exeminetic per steted.	edge, deeth n end/or inv	occurred at the t estigetion, In my	ime, date end plece, opinion, death occur	end due to the c red at the time, d	euse(s) end m ete and plece,	enner es sta end due to	ited. the ceuse(s)	
Me	29b. Signeture end title of certifier 29c. License number							29d. Dete signed (Month, L		Pay, Year)	
9	) 6	Corne	ueall		2	00143			18-0		
	30. Name end eddress of person wh	o completed ceus		23e) (Type, 1 15 Fs	onllie	St. Ca	ulnie	Ge M	122	1613	
State Registrar	31. Dete filed (Month, Day, Year)	-	egistrar's Signetu	Te /	9. Soc	11	0	1 1			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Martha Winslow Certificate of Death nt's Name (First Middle Last) 2. Data of Death **Physician** Month September 11:30am 2000 /Medical 4a. Facility Name (If not institution, give street end numbar) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Howard County General Hospital Columbia Howard 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Sacurity Number 9. Birthplace (State or Foreign Country) New York 6. Sax 8. Data of Birth (Month, Day, Year **Funerai** 1□ M 2⊠ F Days Hours Yrs. 072 03 7573 82 Director Sept 3, 1918 Usual Rasidance of Dacedan 10a. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 IXNo Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? ŏ Items 23a 3004 North Ridge Road Apt 301 21043 Funeral United States 14. Raca - American Indien, Black, Whita, atc. 12. Was Decedant Evar in U,S Armed Forces? 13. Wes Dacedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 72 hours after 1 Navar Marriad % Married 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Dates: Baltimore, Maryland 21215-0020 "natural", or 1□ Yes 2√2 No Specify. by 3 ☐ Widowed 4 ☐ Divorcad white Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "nany Injury or other traumatic event, the Med Elamentary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Malden Sumama) John B. Wood Edna Craft 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 3004 N. Ridge Road Apt 301 Ellicott City, MD 21043 George H. Winslow/Husband 20b. Placa of Disposition (Nama of cematery, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Spacify) Metro Crematory 9-8-2000 Catonsville, MD 21. Signature of Funaral Sarvica Licansea 22. Nama and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. Allmo 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximeta Intarval Batween Onset and Deeth **Physician** /Medical Immediate Cause (Final diseese or condition rasulting in daath) Examiner Examiner EBNEOUAXEVYRA the death certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Enter Undarfying Causa (Disaasa or Injury that initiated events rasulting in death) Lest Dua to (or as a consequence of): and physician ar Box 68760. JUSTABFI WEEN Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. ed by the a Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Wara autopsy findings evailable prior to complation of causa of daath? 24a. Was an autopsy peen Seu 1 Yas 2 DONo 1 ☐ Yas 2 ☐ No Division of Vital 25. Was casa referred to medical axaminar? Be 26. Placa of Death (Check only one) Hospital: Othar: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) To 1 ☐ Yas 2 No 12 Inpatiant 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) funeral 27. Manner of Death Certification: 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred the Hospital or Attending 1X Natural 5 Panding after death. Investigation 1 Yas 2 No 2 Accidant 100 6 Could not be datermined 3 ☐ Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straet, factory, offica building, atc. (Specify) 4 Homicida 124 hours a pelli Cartifying Physician: To the bast of my knowladga, death occurred at tha tima, data and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier pletely (Check only one) To the Hithin 2 To the F 29c. License number 29d. Date signed (Month, Dey, Yaar) Sept 8, 2000

State Registrar

31. Data filad (Month, Day, Year) SEP 1 1 2000

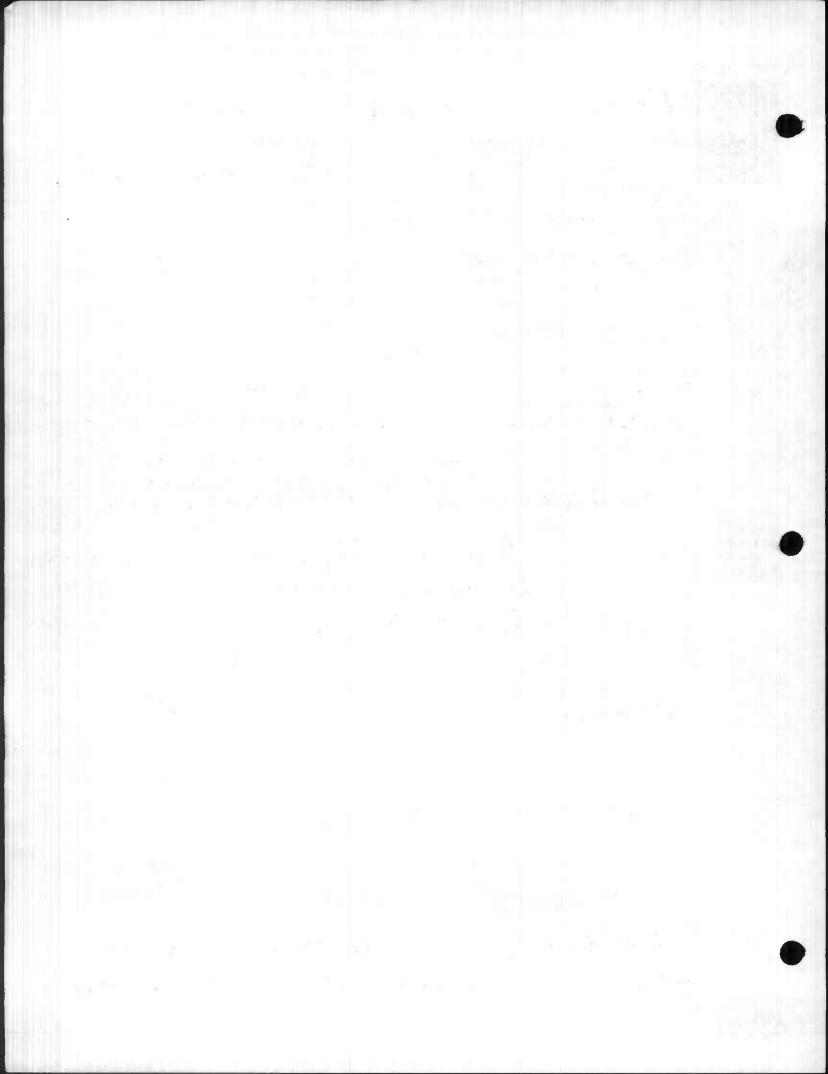
Year)
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32 Registrar's Signatura

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30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print)

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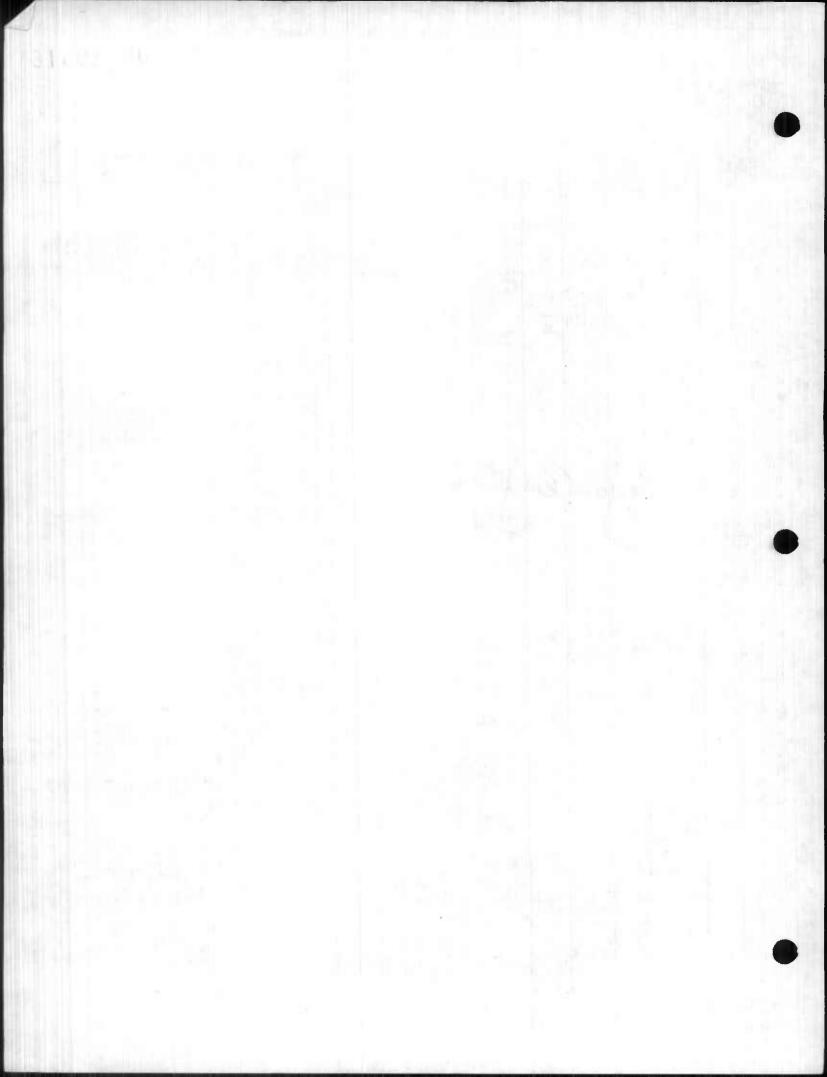


State of Maryland / Department of Health and Mental Hygiene

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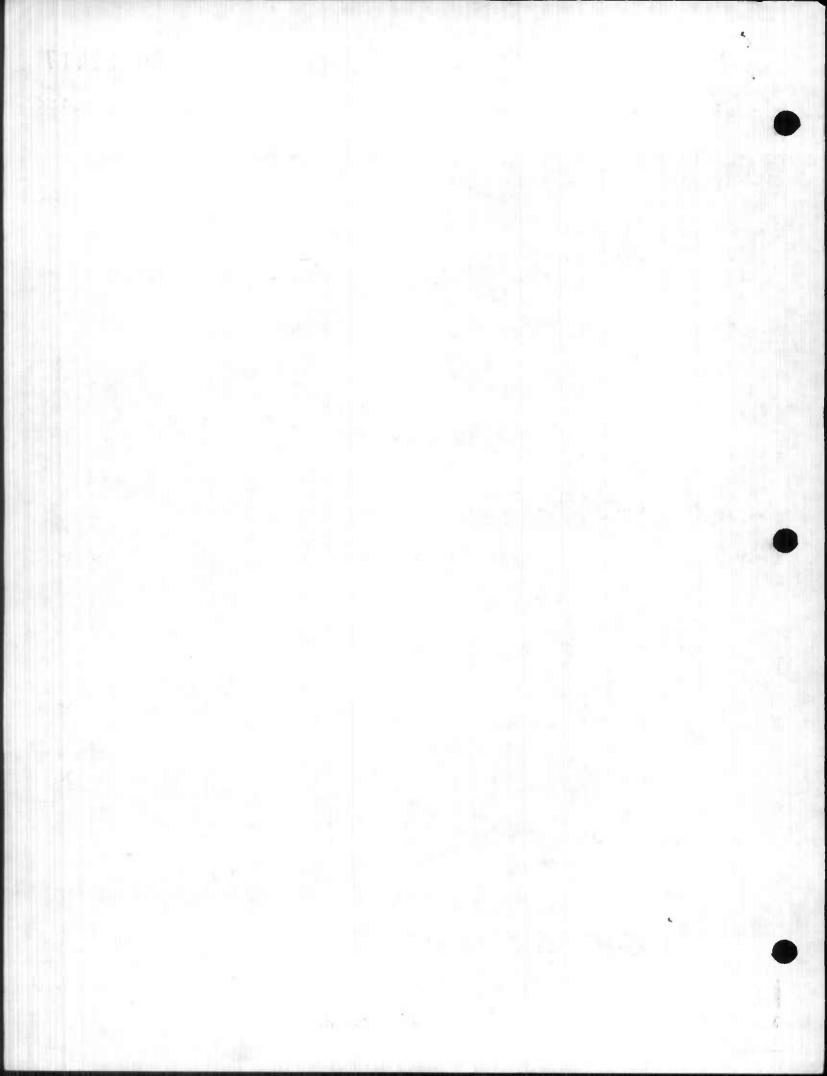
1				Cer	tificate of	Death		Reg. No.		
	1. Decedent's Nama (First, Mid	dle, Last)					2. Data of D Month	Death Day	Yaar	3. Time of Death
Physician /	Joseph	Pietro	Ard	iti			SEPTE	MBER 15,	2000	00:45 AM
/Medical Examiner	4a Facility Name (If not instituti	ion, give street and numb	ber)			4b. City, Town,	or Location of Des	ith 4c. County	of Death	-
Examinici	INTERSTATE 83	AND INTERS	STATE 69	5		Luthe	rville	BALT	IMORE	
	5. Social Security Number		. Age (tn yrs. last		If Under 1 Year	If Under 24 h	rs. 8. Dete of B	irth	9. Birthpi	ace (Stata or Forei
Funeral Director	219-15-6646	1 M 2 □ F	24	Yrs.	Months Days	Hours M	lin. (Month, E	19, 1975	Count	yland
	Usual Residence of Decedent		27				Верс	17, 1775	1141	Jiana
ž u	10a. State 10b. Coun	ty	10c. City, T	own or Loc	eation				10	d. Inside City Limit
to let	Maryland Bal	ltimore		Tim	onium					1 ☐ Yes 2 🔯 N
or 28a-1 a be notified Director	10e. Street and Number	LCIMOIC		LIL	10f. Zip Code			10g. Citizen of V	What Count	Inv?
2 2						200				
r lisers 23s or 24s-f sho siner must be notified at Funeral Director	7 Tyburn Cour		lant Ever in U,S.	12 1	210		(Specify Yas or N	US	A - America	an Indian
Un Ch	11. Marital Status	Armed Force	es?	If.	Yes, specify Cub	an, Mexican, Pu	arto Rican, etc.)		ck, White, e	
by F	1 Never Married 2 Married 3 Widowed 4 Divorce	If Yes, Give		1	☐ Yes 21 No	Specify:		Specify	y:	
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r. the Medical	15. Decede (Specify only high	ent's Education last grada completed)	1	(Give I	ent's Usual Occup kind of work done	during most of	working	16b. Kind of B	usiness/ind	ustry
du	Elementary/Secondary (0-12	College (1-4	4or 5+)	life. D	OO NOT use retire	id)				
00	12	1 1/2		Bar	tender				urant	
e e	17. Father's Name (First, Middl	e, Last)				18. Mother's I	Name (First, Middle	le, Maiden Sumen	ne)	
To	Joseph Mattl	new Arditi,	Jr.			Silva	ina	Zane11	otti	
***	19a. Intormant's Name/Relatio	nshlp (Type, Print)		19b. Mailin	g Address (Stree	t end Number or	Rurel Route Num	ber, City or Town,	Stete, Zip	Code)
	Joseph M. A	Arditi, Jr.,	/Father	7 T	yburn Co	ourt, Ti	monium,	MD 2109	3	
	20a. Method of Disposition			e of Dispos	sition (Neme of	and l	Date	20c. Location	City or To	wn, State
	1 ☐ Buriai 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		tate	• erery, crem	sition (Neme of netory or other ple	Cremat	ory		26	
	21. Signal Funeral Service	-04	Balt		-Washing		9/18/00	Laurel	, Mar	yland
	21. Signal and Puneral Service	Maris			mmon Fur		me			
		Clary		10	W. Pado	onia Roa	d, Timor	nium, MD	2109	3
	23a, Part1. Enfor the dweasa, shock, or heart faure. Li	or complications that cause	used the death. I	Do not ente	or the mode of dyi	ing, such as care	diac or respiratory	errest,		Approximate Interval Between
fal-transit Examiner	Cognosticilly list conditions	b	Due to (or as	145			id Inju			
=	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury	J	5001010101	3 d 00/130q	301102 017.					
S 2	that initiated events resulting in death) Last	d	Dua to (or as	s a consequ	Jance of):					
detached for us	Part II Other significant condi	tions contributing to doe	th but not requisi	an in the un	dorluina pausa si	iven in Rest i	22h Di	d tobacco use co	ntelbute to	the cause of de
or series	Part II. Other significant condi	tions contributing to dea	IIII DUL NOL 195UIIII	ig in the di	idenying cause gi	ven in Fatti.	<   (	_		pably 4 Unkn
								Yea 25 No	3   110	Albiy 4 Oliki
d by							24a W	as an autopsy	24b. We	ere autopsy finding
Completed								rlormed?	001	ailable prior to impletion of causa
du									of	death?
00							16	₹Yes 2□No	104	Yas 2 No
Be	25. Was case reterred to media	cal				26. Place of	Death (Check only	y one)		
0	axaminar? fX□ Yes 2□ No	Hospital:	petient 2□ER	VOutpetien	t 3□ DOA Ot	her: 4 Nursin	g Home 5 ☐ Ra	sidence 6 DOtt	ner (Specify	) SCENE
12	27. Manner of Death	28a. Date of	Injury 28 Day Year)	3b. Time of	28c. Inju			e how injury occur		- SHELLING
i	1 Netural 5 Pane 2 Accident inves	tigation		Injury		Yes 2 No	motor	vehicle a	cuelon	+
Certification:	3 Suicide 6 Coul	d not be 28e. Piace o	t Injury - At home		et, tactory, office		28f. Location	(Street and Numi	ber or Rure	Routa Number,
Ta	4 Homicide	building	g, etc. (Specify)	street			City or 7		695 A	
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edical		ring Phyalcian: To the b at Examiner: On the bas and manne	is of examination							
2	29b. Signature and title of certif	lier			29c. Licen	se number		29d. Data signe		
	New.	100	sut no		OC	ME		SEPTEM	BER 1	5, 2000
1	30. Nama and address of person	un who completed cause	of death (Item 2)	Re) (Tune	Print)					
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32	Dennis J	Chute my	atalawa or a s	111 P	enn Stre	et, Bal	timore, 1	Maryland	2120	1
State gistrar	31. Date tiled (Month, Dey, Yea	9 2000 D	gistrar's Signatur	19	Low	E.				
<del>J.Strui</del>	OLI	0 LUUU /	4		More	1 - 10				



/sician ledical	1. Decedent's Neme (First, Middle, La  Sharon  4a Facility Name (If not institution, giv	Bun				4b, City, Town, o	2. Date of D Month Lep Te r Location of Dea	mkr 08	Z000 16	a of Death
aminer	Lorien Nursing			t Home		Columbia			Howard	
eral ctor	5. Social Security Number 6. S		pe (In yrs. last	birthday) If	Under 1 Yeer Ionths Days		s. 8. Date of B		9. Birthplace (Sta	nte or Foreig
	Usuel Residence of Decedent  10a. Stete 10b. County		10c City T	own or Locati	on				10d Ineid	e City Limits
O.		Howard	100. Oky, 1		lumbia					Yes 2 No
Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V	What Country?	
	6334 Cedar Lane					21044			USA	
by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces 1  Yes 2 X If Yes, Give Year or Dates:			Decedent of I es, specity Cub Yes 2 No		Specify Yes or Norto Rican, etc.)	o- 14. Rac Blac Specify	e - American Indiar ck, White, etc. White	١,
Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or		6a. Decedent (Give kind life. DO	's Usual Occup d of work done NOT use retire	oation during most of w d)	orking	16b. Kind of Be	usiness/Industry	
Co	12	4		prac	ctical				health	
Be	17. Father's Name (First, Middle, Last) Grant R. Snook							e, Meiden Sumen	ne)	
7	19a. Informant's Neme/Reletionship (	Tyne Print)		19b Mailing A	Address (Street		E. Will:	Lams ber, City or Town,	State. Zip Code)	2
	Julia Snook/mothe			-				Lliamspor		1795
	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☒ Donetion 5 ☐ Other (Specify		20b. Place	e of Dispositio			Date		City or Town, State	
	21 Signature of Funeral Service Licer Joseph	Van Sant		St				W. Balt	imore St	reet
n al m	Immediate Cause (Final disease or condition resulting in deeth)		nltip		clero		ec or respiratory	arrest,	Approxi Interval Onset a	Between and Deeth
dical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events	b		a consequen						
	resulting in death) Last	d							1	
by Physician/M	Pert II. Other significant conditions of	ontributing to death t	out not resultin	ng in the unde	rlying cause gi	ven in Part I.		tobacco use co	3 Probably	Unknow
Completed by								s an eutopsy formed?	24b. Were sutop available pi completion of death?	rior to
E O							18	Yes 2 No	1 ☐ Yes	26No
Be	25. Was case referred to medical examiner?						eath (Check only	one)		
9	1 ☐ Yes 2 No	Hospital:		•	3LI DOA	45.45		sidence 6 Oth		
Certification:	27. Manner of Death    Matural 5   Pending 2   Accident investigation 3   Suicide 6   Could not b					ry at rk? ] Yes 2 □ No		how injury occur		A1 h
Certifi	4 Homicide determined	building, e	c. (Specify)		, factory, office		City or T	own, State)	ber or Rural Route	vumber,
Medical Certifi		nysician: To the best niner: On the basis of end manner st	f examination							ise(s)
Me	29b. Signature and title of certifier	Seal 1	10. sh	٥	29c. Licen			,	er 11, 20 14 more,	
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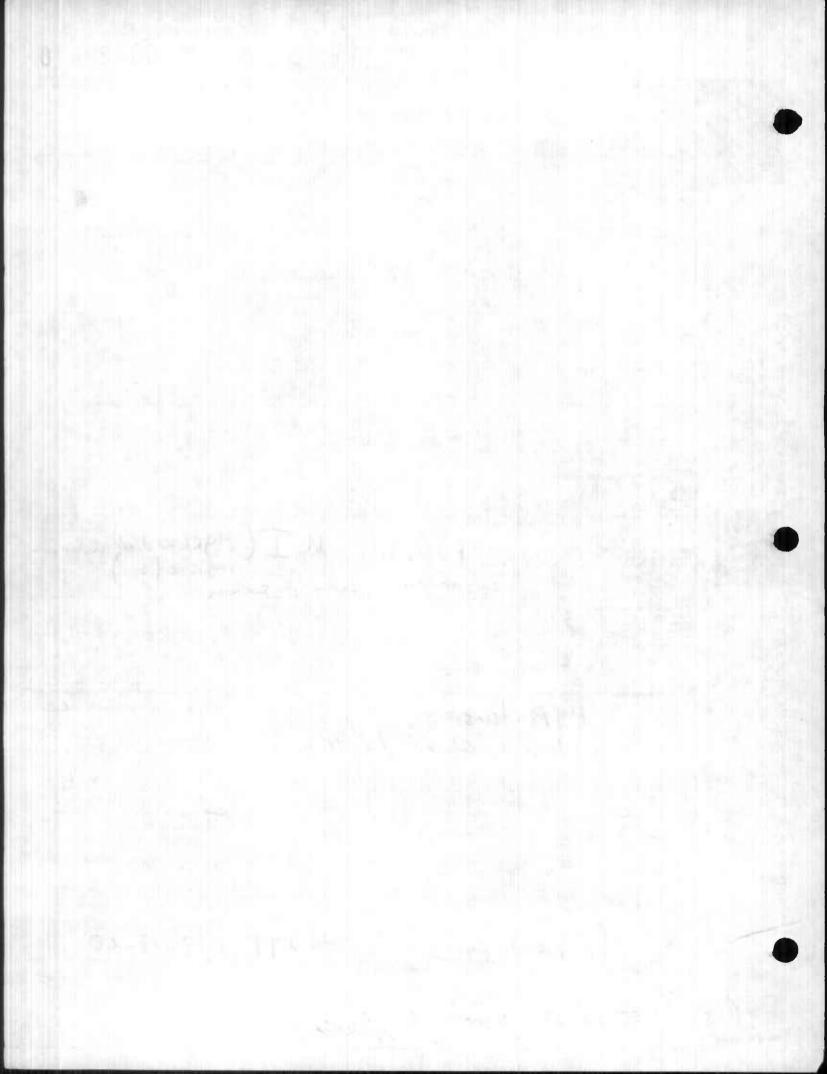


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 9 18 Day **Physician** 5:30 AM Mary Gloria Bond /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 21 Florida Road Baltimore Towson If Under 1 Yeer | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Numbe 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 XX Yrs. 219-18-4243 Director 8-15-1922 Maryland Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits mast be notified at 1 ☐ Yes 2 ☐ No Director Mary land Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21204 U.S.A. 21 Florida Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Herna. 14. Rece - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Bleck, White, atc. filed within 72 hours efter 1 Yes 2 No
If Yes, Give
Year or Detes: 1 Never Married 2 Married 21215-0020 6 1 Yes 2 No Specify: ģ Specify: 3 Widowed 4 Divorced White "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Hygiene. College (1-4or 5+) Homemaker Own Home Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, . Pages 1 end 2 should be file timent of Health end Mental Hy tant: If Itam 27 is marked oth jury or other traumatic even Elizabeth Eisenhardt R. Callis George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) same as #10a - #10f Robert Bond 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriai 2☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or Hilltop Ser. Co. 9-21-00 Towson, Md. 22. Name and Address of Fecility
Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licenses 1050 York Rd. Towson, Maryland 21204 23a. Part1. Enter the queene or composition, that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Physician/Medical Examiner nding physician and use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the causa of death? as been signed by the 2 should be detached 1 Yaa 2 No 3 Probably 4 Linknown of Vital Records. g 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy Be Completed oric Atrial fibrillation page 1 ☐ Yes 2 ☐ No 1 Tyes 2 No Hospital or Attending Physician: 25. Was case referred to medicei 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 524 Residence 6 Other (Specify) 1 Yes 2 Ne Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Division 5 Pending investigation 1 Natural after deeth. 1 ☐ Yes 2 ☐ No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Atterwithin 24 hours after der To the Funeral Directo completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piace, and dua to the cause(s) and manner stated. 29a. Cartifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print) 7600 Osler Drive, Suite 411, Towson, Md. 21204 Fahed Kouli, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signeture SEP 1 9 2000 Registrar

DHMH 16 Rav 6/95

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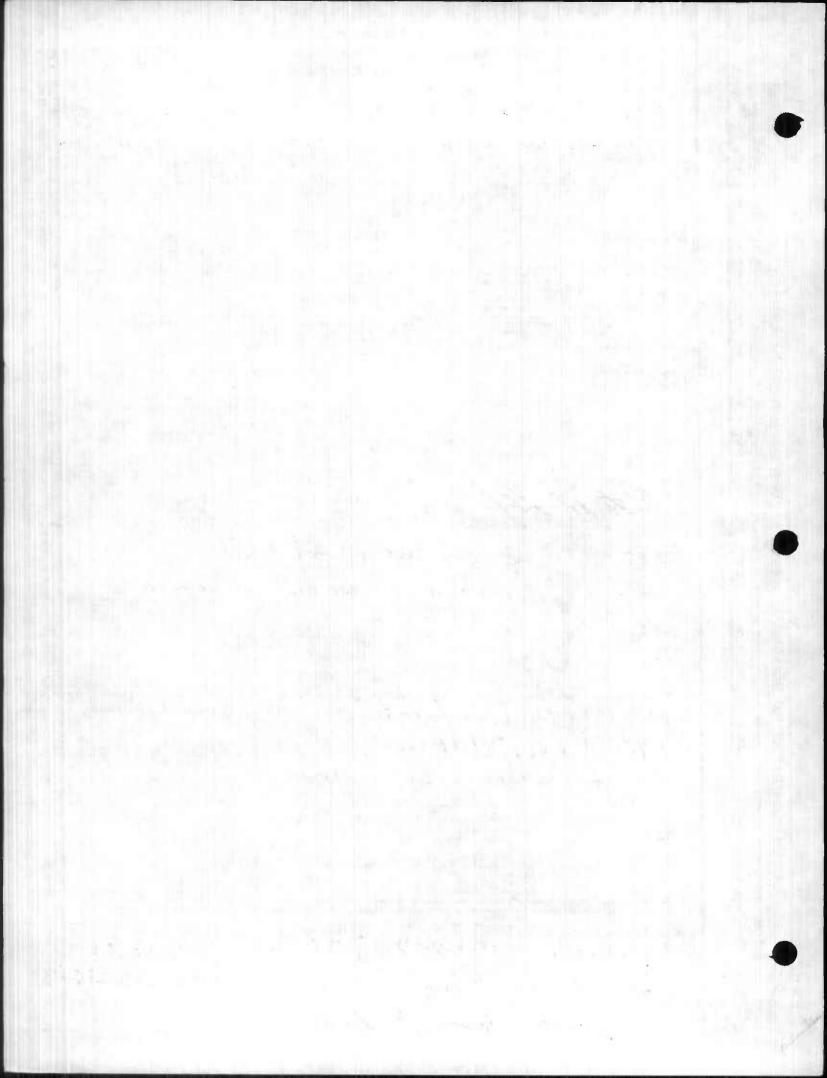


State of Maryland / Department of Health and Mental Hygiene () 201, 10

				Certificate	of Death		g. No.	.9419
	Physician	1. Decedent's Neme (First, Middle, Last)		)		2. Date of Death Month	Day Year	3. Time of Death
9	Physician /Medical	111110	vcis :	Slooks		04	16 00	2:15P
)	Examiner	4a Facility Neme (If not institution, give sin MANIALD BAY CO			4b. City, Town, or L		4c. County of Death	
ı.		5. Sociei Security Number 6. Sex	T. Age (In yrs. Ia:	st birthday) If Under 1	Yeer If Under 24 Hrs.	BGE 8. Date of Birth	Q Girth	CS+EC place (State or Foreign
1	Funeral Director	212-12-2016	M 2⊠F 84	Yrs. Months	Deys Hours Min.	1/14/19	16 Mai	plece (State or Foreign intry) Cyland
	2 1	Usuel Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
	28a-f sho notified a rector	MD Dorcheste	r Mad	ison				1 ☐ Yes 2 🖾 No
	or 28a-f s be notified Director	10e. Street and Number		10f. Zip (	Code	10	g. Citizen of What Cou	intry?
	23e ant b	1105 Taylor's Isla			1648		U.S.A.	
21215-0020	ours after death v et, or here 28e Examiner must by Funeral	11. Meritel Stetus  1 Never Merried 2 Merried  3 Nover Merried 4 Divorced	2. Wes Decedent Ever In U,S. Armed Forces?  1  Yes 22 No If Yes, Give Yeer or Detes:	13. Was Decede If Yes, specif	int of Hispanic Origin? (Spry Cuban, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	14. Reca - Amer Black, White Specify: W	
5-0	72 h	15. Decedent's Educ (Specify only highest grade	ation completed)	16e. Decedent's Usuel (Give kind of work	Occupation done during most of work retired)	sing 1	6b. Kind of Business/in	ndustry
121	ed within 72 ho yglene. wr then "mehun 4, the Medical J Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Homemaker	retired)		Own Home	
d 2	tal Hygin d other event, g	17. Father's Neme (First, Middle, Last)			18. Mother's Nem	e (First, Middle, M	aiden Sumame)	
/lan	Mental Me	Henry Miller			Cather	ine Henna	amen	
Maryland	2 sho and 1 is me	19a. Informant's Neme/Reletionship (Typ	e, Print)		Street and Number or Rui			
-	1 and Health Im 27 ther to	Barbara Thompson  20a. Method of Disposition	20h Ple	ca of Disposition (Name	or's Island		Oc. Location - City or T	
altimore	Pages ment: If he lury or of	1 ☑Burial 2 ☐ Cremetion 3 ☐ Re 4 ☐ Donetion 5 ☐ Other (Specify)	movel from Stete	kwood Cemet	ner placa)	37	Baltimore,	
Ball	Depart Depart Import any in	21. Signature of Euneral Service License	Il.	6415 Be	elair Road B	altimore		21206
J.		23a. Part1. Enter the disease, or complice shock, or heart feilure. List only one	etiens at caused the deeth.	Do not enter the mode	of dying, such es cardiec	or respiretory erre	st,	Approximate Intervat Between
	Physician /Medical	Immediate Cause (Final disease or condition	Couge	stire A	cort fo	ai/vr		Onset and Death
	Examiner	resulting in death) e.	Cough 1scHs	es a consequence of):	16 ANT	DISE	ASC	
	ficate be executed physician and is the burial-transit edical Examiner	Sequentially list conditions,		es a consequence of):		. 77		
68760,	be ex	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events						
	5 D 0 -	resulting in death) Last	Due to (or a	is a consequence of):				
Box	that the death certificated by the attending phy detached for use as the thy sician/Med	d.						
0	y the a	Pert II. Other aignificant conditions cont	ributing to death but not	ing in the underlying ca	use given in Pert I.			to the cause of death?
0	파 전 등 주	Myscard	cal sufo	renn		1970	a 2 No 3 Pr	obably 4 Unknown
Records,	requi	Arriel Go	brillat	in		24a. Wes an perform	ed?	Vere autopsy findings vailable prior to empletion of cause
	sicien: The law certificate has b lirector, page 2 s o Be Comple	Organie	Brain.	Synd	orap	1 ☐ Ye		death?
Vital	entifica ector,	25. Was case referred to medical examiner?		0		th (Check only one	9)	
of	A Sign	10 100 20 100	1 Inpatient 2 E				nca 6 Other (Spec	eity)
no	After funer funer	1 Naturet 5 Pending investigation	28a. Dete of Injury (Month, Day Year)	28b. Time of 28 tnjury M	c. tnjury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred	
Division	Attending r death. octor: After by the fune lfication	2 Accident 3 Suicide 6 Could not be determined	28e. Place of Injury - At hom	ne, ferm, street, fectory,		28f. Location (Str. City or Town,	eet and Number or Ru	ral Route Number,
Ö	Cert	* [] Hornicide	building, etc. (Specify)			City or Town,	, State)	
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral Medical Certification:		clan: To the best of my knowl er: On the basis of examinetic and menner steted.					
	Within To Within	29b. Signeture end title of certifier	Memorial	290.	License number	29	d. Dete signed (Mgntt	n, Day, Year)
	1	Muchael .	, vo lange	1	126100		7114 10	70
1	Wy.	30. Name and address of person who com	npleted cause of death (Item 2	23a) (Type, Print)	TROOF CA	merco	60 MD	2/6/3
1	State Registrar	31. Dete filed (Month, Day, Year)	32. Registrer's Signetu	B So	als			

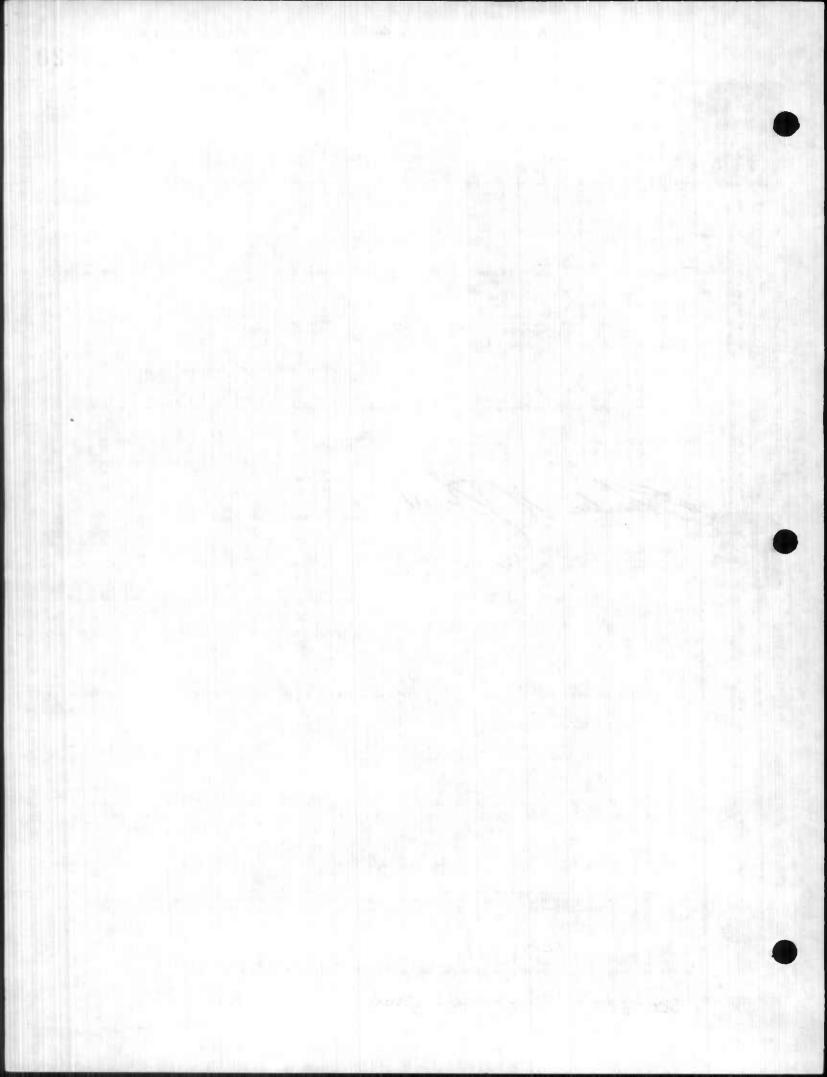
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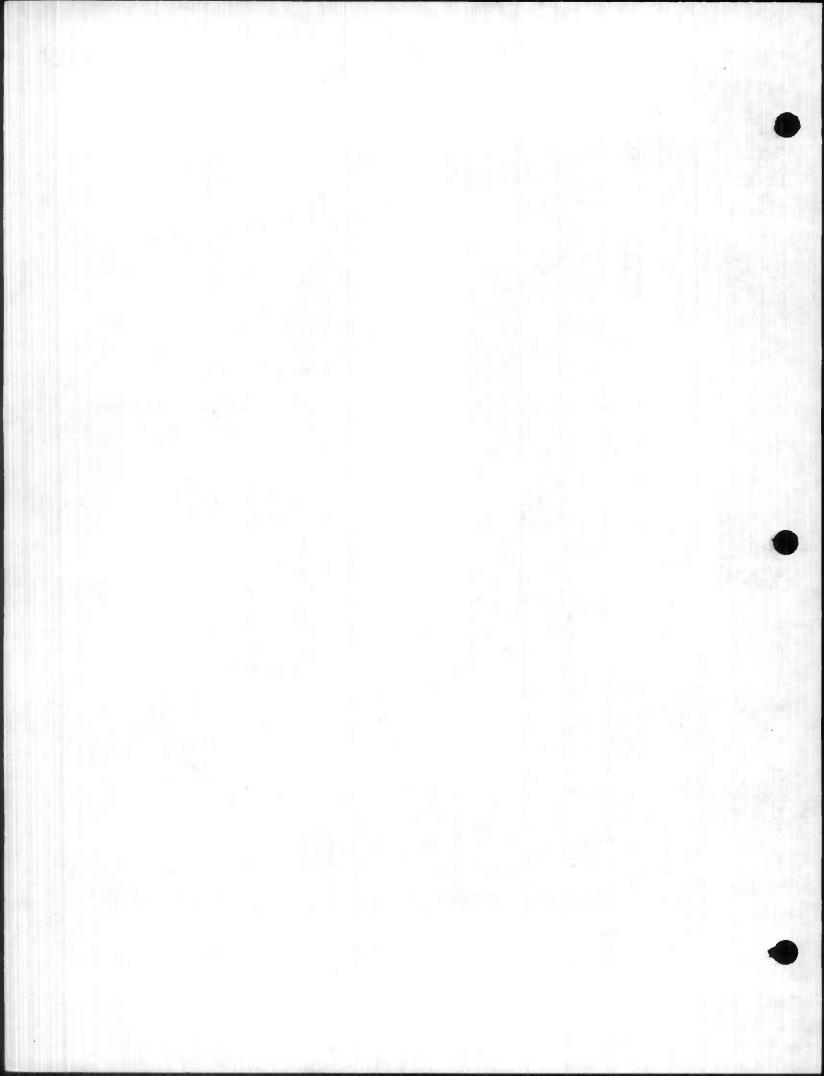
State of Maryland / Department of Health and Mental Hygiene 00 201.20

	1.	Decedent's Neme	e (First, Middle,	Last)					7-17	2.	Date of Death Month	Dev	Year	3. Time of De
ian cal		PIC	CCOLA	BUN	TING					5	eptember	2 12,20		630 pm
ner	4a	Fecility Name (#	f not institution,	give street an	nd number)	1 .			4b. City, Tow	n, or Local	tion of Death	4c. County	of Death	
	1	Deyland	d Grene	ral	HOSPIT	tal			Baltin	more	CHY	N	/A	
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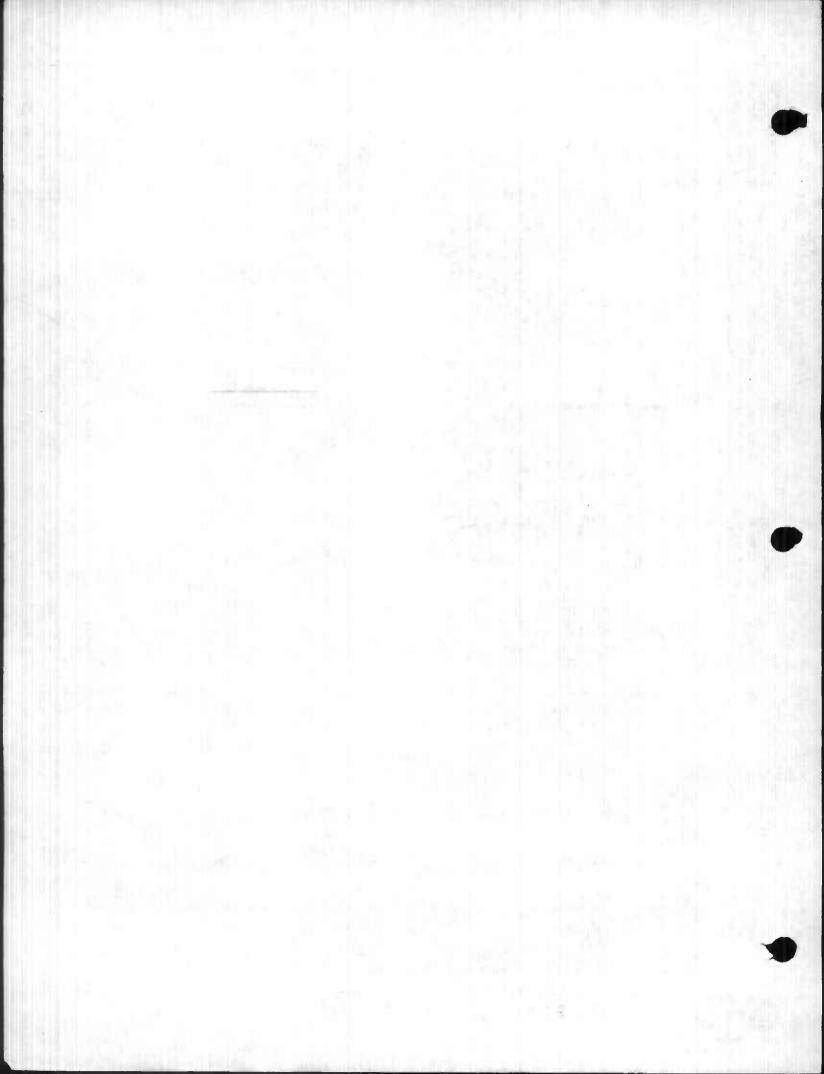
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State of Maryland / Department of Health and Mental Hygiene 0 29422

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Death **Physician** Jack Osborne Chattin 1:11 Am 4b. City, Town, or Location of Death 4c. County of Death /Medical 4e Facility Neme (If not Institution, give street end number) 4c. County of Death Examiner Franklinggrave Hospital Baltimore If Under 1 Year 8. Date of Birth (Month, Dey, Year) Feb. 28, 1919 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Months Deys Hours 81 403-18-3929 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Maruland Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 4407 Blakely Avenue 21236 U.S.A. 238 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 11 Merital Status 1 X Yes 2 No If Yes, Give WW II Yeer or Detes: WW II 1 Never Merried 2 Merried 1 ☐ Yes 2 👿 No White Specify 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 12th Grade College (1-4or 5+) Health Care Director of Purchasing 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Edward Chattin Charles Nina Lee Woodard 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health / Mrs. Mary F. Chattin 4407 Blakely Ave., Baltimore, MD (wife) 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burlal 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 9/19/00 Baltimore, Maryland Green Mount Crematory 21. Signeture of Funerel Service Licensee 22. Name end Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Atheroscleratic Cardiavascular Examiner Due to (or es a consequence of): Physician/Medical Examiner The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequenca of): Due to (or es a consequence of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy performed? 1 Tes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Neturel 5 Pending after deeth. 1 Yes 2 No 2 Accident investigation 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) end manner es stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the cause(s) and menner stated. 29e. Certifier 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dev. Year) ne Amil. Casami MO D28214

State Registrar

DHMH 16 Rev 6/95

Box 68760.

P.O.

Division of Vital Records,

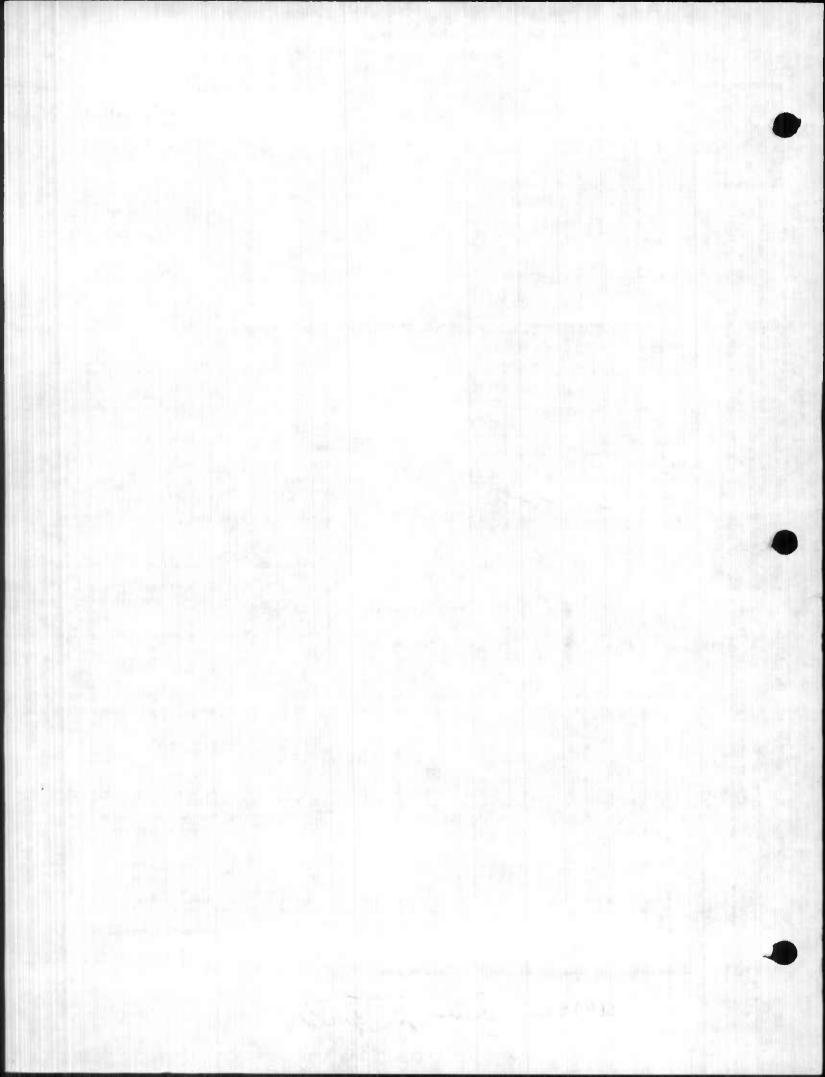
rive Baltimore, Mary land 21237

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month SEP 1 9 2000

atani mD. 9000 Franklin Square

32. Registrer's Signeture

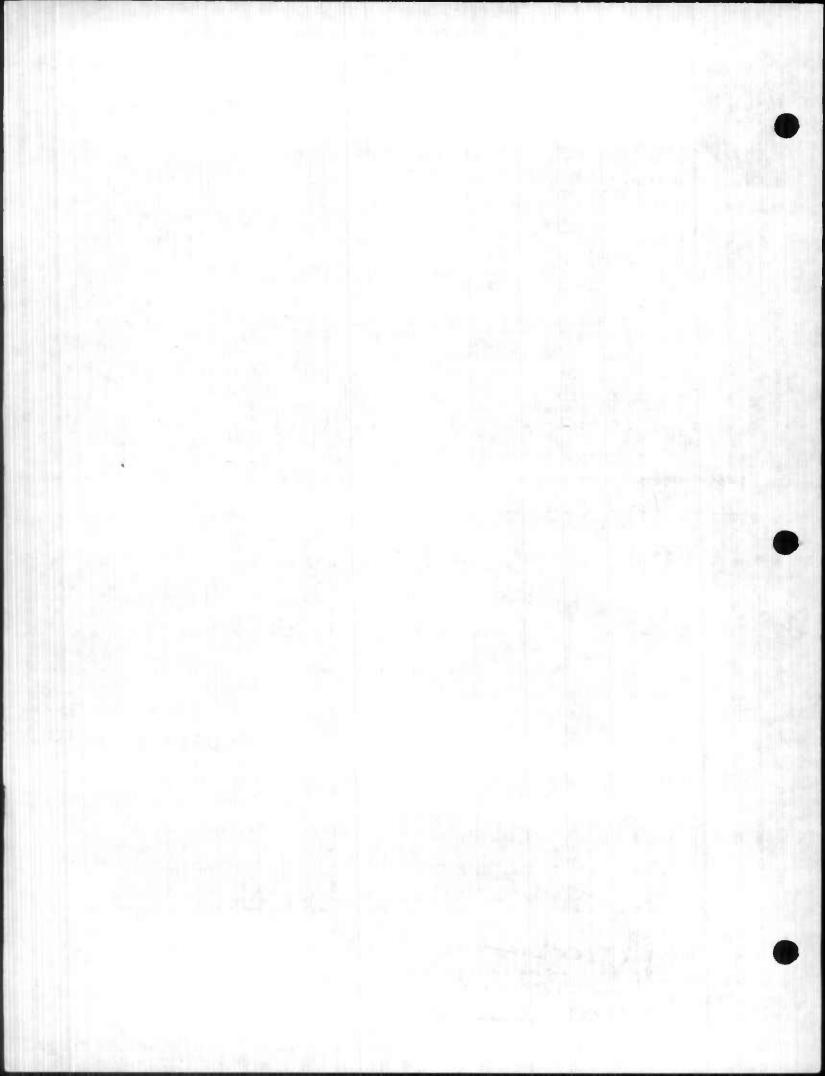


State of Maryland / Department of Health and Mental Hygiene 00

AMEND	ITEM: #4b-CPART I, PER MEO G78 Certificate of Death	Reg. No.
Physicial	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year 3. Time of Death
/Medica	paniel Llush	Bept. 5th 200 7 pm
Examine	TOTAL CONTRACTOR OF THE PROPERTY OF THE PROPER	
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	
Funeral Director	2 19-16-8845 12 M 2 F 75 Yrs. Months Deys Hours Min.  Usuel Residence of Decedent	8. Dete of Birth (Month, Day, Year) 9. Birthplece (State or Foreign Country) Md
ahow	10a. Stete 10b. County 10c. City, Town or Location	10d. Inside City Limits
the Maryle 28a-f sho	Md N/A Baltimore	1 🖄 Yes 2 🗆 No
with the Maryland a or 28a-f ahow	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
death w	2643 S. Paca Street 21230	USA
020	Md N/A Baltimore  10e. Street and Number  2643 S. Paca Street  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  N/A Baltimore  10f. Zip Code  21230  11. Wes Decedent Ever in U.S. Armed Forces?  12. Wes Decedent Ever in U.S. Armed Forces?  12. Wes Decedent Ever in U.S. Armed Forces?  13. Wes Decedent of Hispenic Origin? (Spire Yes, Spire Yeser or Detes)  1 Yes 2 No Specify:	Pecify Yes or No-Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: Black
72 houn	15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondery (0-12)  10th grade  16e. Decedent's Usual Occupetion (Give kind of work done during most of work life. DO NOT use retired)  Laborer	16b. Kind of Business/Industry
2121 f within jiene.	Elementery/Secondery (0-12) College (1-4or 5+)	Bethlehem Steel
	10th grade N/A Laborer 17. Father's Neme (First, Middle, Last) 18. Mother's Nem	e (First, Middle, Maiden Sumeme)
E Saby	m l	
Maryla d 2 should th and Mer 7 Is marke traumatic	- Daniel Of Oldon, O.	ral Route Number, City or Town, State, Zip Code)
CENL	Heidi D. Curtis-Granddaughter 2643 S. Paca Street	Baltimore, Md 21230
other other	20e. Method of Disposition  20b. Place of Disposition (Name of cemetery, cremetory or other place)	Dete 20c. Location - City or Town, State
Page Dent of iny or		-11-00 White Marsh, Md
Baltimore, pemit. Pages 1 at Department of Hea Important: If Hear; any Injury or other	21. Signeture of Funeral Service Libensee  22. Name end Address of Fecility March F/H West 4300 Wabash Avenu	e Baltimore, Md 21215
STATE STATE OF	23a. Part Enter the distance or complications that caused the deeth. Do not enter the mode of dying, such as cardiac shock or hear failure. List only one cause on each line.	
Physician /Medical Examiner		uRTI
6876 ficate be physicia as the bur	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequenca of):	EXTREMETIES
P.O. that the de detached	Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobacco use contribute to the cause of death?
P. P.		1 Yss 2 No 3 Probably Unknown
Division of Vital Records, P.O or Attending Physician: The law requires that the after death.  Director: After this cardificate has been signed by the line by the funeral director, page 2 should be detached.	Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	24e. Was en eutopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?
The law ata has page 2	<u> </u>	1 Yes 2 No 1 Yes 2 No
ysician: The		th (Check only one)
Of Vita Physician: this cartific ral director,	1 Yes 20 No Hospitel: 1 Inpatient 2 ER/Outpatlent 3 DOA Other: 4 Olursing H	ome 5 Residence 8 Other (Specify)
OID O		28d. Describe how Injury occurred
Attending or death.	2 Accident investigation M 1 Yes 2 No	28f. Location (Street end Number or Rural Route Number,
or All	28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)	City or Town, State)
ours ours lilled	29e. Certifier 16 Octifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa,	and due to the cause(s) and manner as stated
DIVISION To the Mospital or Attendamin 24 hours after death To the Funeral Director: completely filled in by the	27. Meriner of Death   Neture    5   Pending investigation   2   Accident   5   State of Injury   2   Accident   5   State of Injury   2   Accident   3   Suicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   28e. Place of Injury - At home, farm, street, factory, office   28e. Place of Injury - At home, farm, street, factory, office   29e. Certifier   1   Octubring Physician: To the best of my knowledge, deeth occurred et the time, dete and place, one)   Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred end menner steted.	rred at the time, date and place, and due to the cause(s)
To the comp	The state of the s	29d. Date signed (Month, Dey, Year)
1	1)24/00	09-07-2000
Y	30. Name and andress of person was simpleted cause of death (Item 23a) (Type, Print)  RABHAKAR M.D. 300 AR	290. Date signed (Month, Day, Year) 09-07-2000 PMORY PLACE BAL, MO
State Registra	31. Date filed (Month, Dey, Year) 32. Registrer's Signature  SEP 1 9 2000  Server  4	

DHMH 16 Rev 6/95

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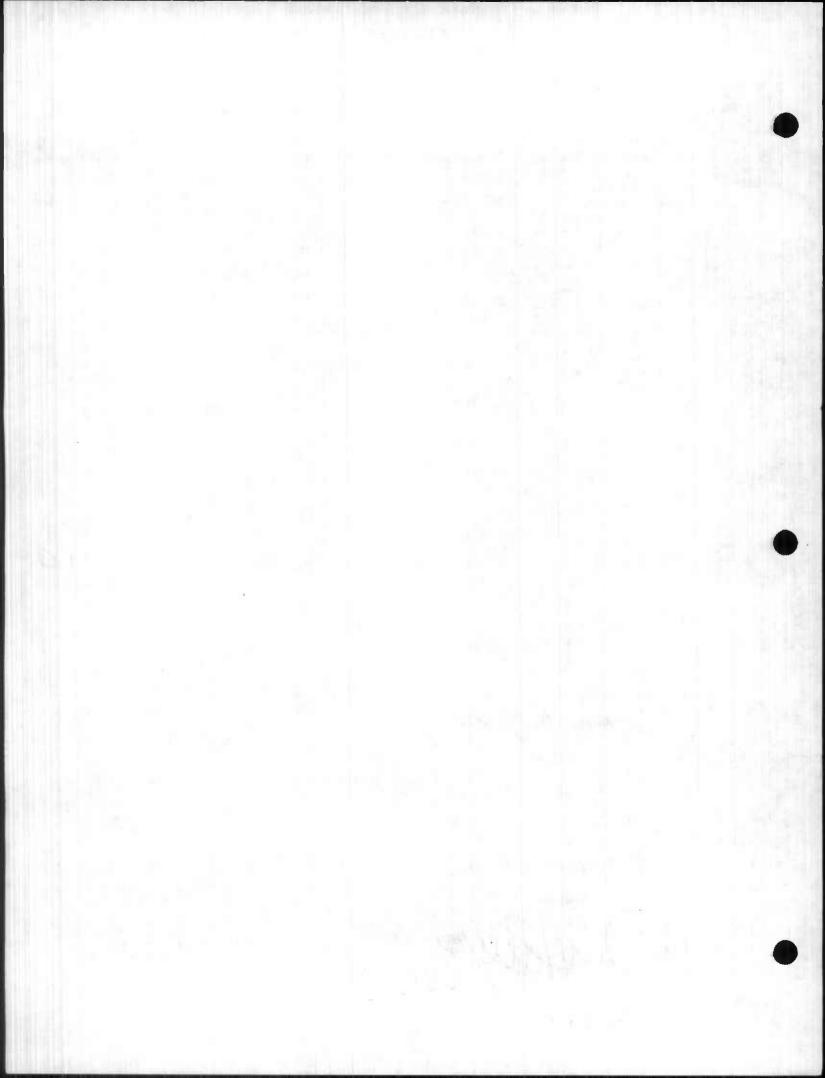
State of Maryland / Department of Health and Mental Hygiene

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		State of		epartment of H Certificate of I			giene () Reg. No.	0 2	29425
Physician	1. Decedent's Name (First, Mic					2. Date of De	Day	Year	3. Time of Death
/Medical	Robert John C.			- 4	lb. City, Town, or I	Sept.	17, 200		7:12 am
Examiner	Civista Medic				LaPlata			rles	
Funeral Director	5. Social Security Number 226-72-5505	6. Sex 1 X M 2 □ F	7. Age (In yrs. last birti	nday) If Under 1 Yeer Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, De	h y, Year) 1950	9. Birthpla Countr Virg	ice (Stete or Foreign y) inia
11.	Usual Residence of Decedent  10a. State 10b. Cour	nty	10c. City, Town	or Location				100	d. Inside City Limits
Mary 4 she fied a	1 1 0		LaPlat						1 ☐ Yes 2 No
vith the Ma t or 28a-f s be notified Director	10e. Street end Number	1000		10f. Zip Code	HELD IN	1 5-4	10g. Citizen of V	Vhat Countr	y?
23a o all D	6705 Bumpy Oa	k Road		20646			USA		
urs shar death v er, or hams 23e Examiner must by Funeral	11. Meritel Status  1 Never Married 2 M  3 Widowed 4 Divorce	erried Armed For	2 XNo	13. Was Decedent of H If Yes, specify Cube	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	Biac	e - America k, White, et White	lc.
Maryland Z1Z15-00ZU d 2 should be filed within 72 hours at the and Mernal Hygiene. The and Mernal Hygiene. Traumatic eventl, the Medical Exam To Be Completed by F	15. Deced (Specify only high Elementery/Secondary (0-12	ent's Education hest grade completed)  College (1:	-4or 5+)	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	etion during most of wor d)	king	16b. Kind of Bu		istry
Hygie Other 1 Hent, th	1() 17. Father's Name (First, Midd	le. Last)	Ir	uck Driver	18. Mother's Nen	ne (First, Middle,	Asphal Meiden Sumem	-	
Mental H Mental H wheel off affic ever To Be			r.			ine King			
N D D D D D D D D D D D D D D D D D D D	19e. Informant's Neme/Reletion			Meiling Address (Street				Stete, Zip (	Code)
and 2 and 2 and 2 and 27 and 27	Carol M. Chen	ault/Wife	67	05 Bumpy Oa	k Road	LaPlata,		646	
mil. Pages 1 ar partment of Hea portant: If them? I Injury or other	20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematio	n 3 Removal from S	cameter	Disposition (Neme of cremetory or other plea	(a)	Dete	20c. Location -	City or Tow	n, State
filmer flant	4 Donation 25 Other		Metro	Crematory I		9-18-00	Baltim	ore,	MD
Depa Impo Impo	21. Signature of Funerel Service	Tesar		22. Name and Addre Cremation	Society				
•	Thomas Gr 23a. Part1. Enter the disease, shock, or heert failure. L		aused the death. Do n	299 Frede	rick Road	d Balti	more, M	1	228 Approximate Interval Between
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a	Nelectro (or es e c	onsequence of):/	Parvel		¥	1	Onset and Deeth
certificate be executed ding physician and as as the burts-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as a co						1207
attendin storuse clan/N	Death Other standings at one of			45	an in Day I	ash Did	<b></b>	1	the seven of death?
es that the death cert gned by the attending be detached for use by Physician/M	Part II. Other elgnificent cond	Authorition contributing to de	Pro ,	the underlying cause giv	ren in Part I.				the cause of death? ably 4 Unknown
The law requires to the law requires to the law been signal page 2 should be Completed by	4.5.2					24e. Was	en autopsy ormed?	eva	re autopsy findings fleble prior to appletion of cause eath?
The page Mo	SULVE					10	Yes 2 No	10	lYes 2□No
clant.	25. Was case referred to medi axaminer?	Mosoitai		-1		ath (Check only o	one)		
Physician: The product of the continuation of	1 ☐ Yes 2 No 27. Magner of Death		npatient 2 ER/Out		4 🖂 Nuising r	lome 5 Resi	dence 6 Oth		)
tal or Attending Physics after Gesth, as Biractor: Atter this led in by the teneral of Certification: To	1 Natural 5 Pen 2 Accident Inve	stigation	h, Dey Year) Ir	jury Wor	k? Yes 2 □ No		Street and Numb		Route Number,
he Hospital ha Funeral pletaly filled edical C				deeth occurred at the tir					
Te the Wilthin 2 To the Complete	29b. Signature and title of certi	and mann		29c. Licens	e number		29d. Dete signe		
H	30. Name and address of person		e of death (Item 23a) (		11.11.	100 0000		Tito	E-11/1, 19
State	Daniel M. Howel  31. Date filed (Month, Day, Yea	ar) 32. Re	egistrar's Signature	Sq. Suite 104	Waldorf,	MD 20603			
Registrar	SEP 1	9 2000	Serevas	12 span	63				

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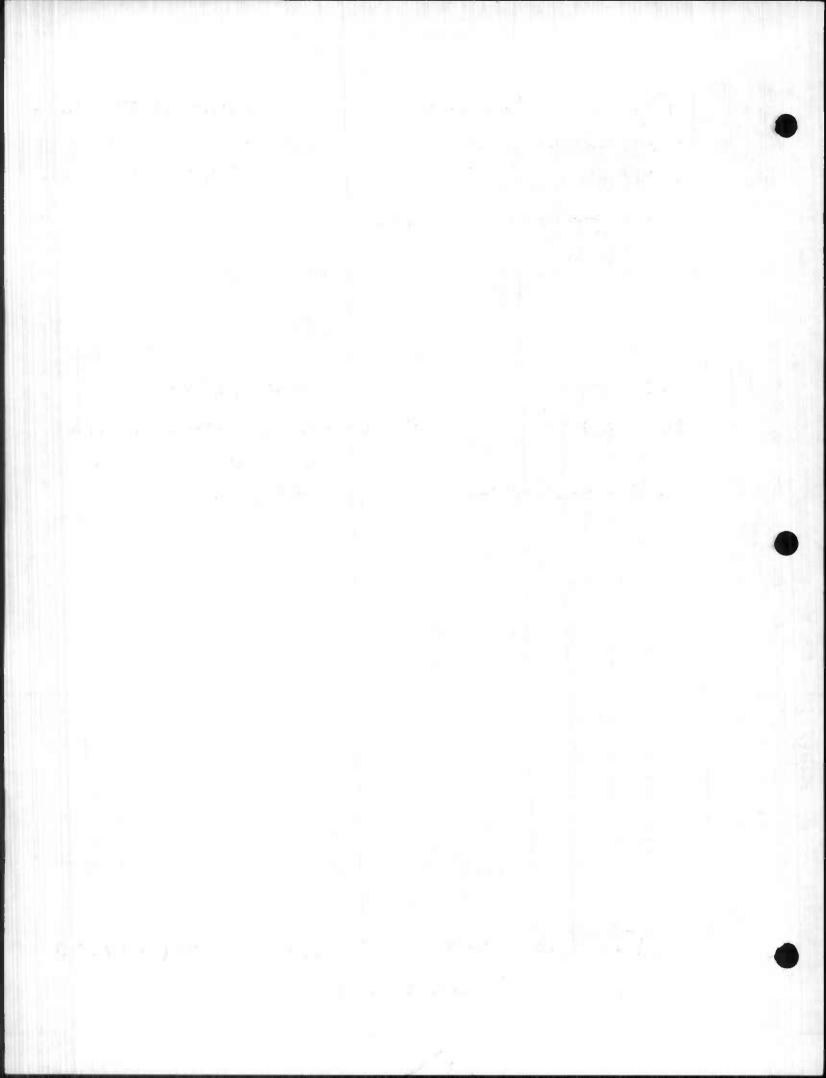


State of Maryland / Department of Health and Mental Hygiene 

\[ \int \] Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month hampion nna September 14 2000 11:30 AM /Medical 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ridgeway Manor Nursing Home Catonsville Baltimore If Under 1 Yaar | if Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) MAY 1, 1909 5. Social Security Number Birthplaca (State or Foraign Country) 7. Aga (In yrs. last birthday) **Funeral** 1 M 2 XF Days 91 Yrs. Director Pennsylvania 168-12-4543 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Modical Examinar must be notified at 1 □ Yas 2 No Directo Maryland Anne Arundel Linthicum Heights 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21090 414 Darlene Avenue USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race · American Indian, Biack, White, atc. 11. Marital Status 72 hours after 1 Nevar Married 2 Married 1 ☐ Yes 2 ☐XNo If Yas, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuai Occupation (Giva kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade comp 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filled within: Department of Health and Mental Hygiene. Important: if Nem 27 is marked other than "rany lijury or other traumatic event, in a Med 2008. Elementary/Secondery (0-12) College (1-4or 5+) Business Woman Self Employed 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Malden Sumame) Be Roy J. Crayton Bertha Agnes McNeal 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) James K. Allis/Son 414 Darlene Ave. Linthicum Heights, MD 2109(
o of Disposition (Name of Date 20c. Location City or Town, State 21090 20b. Place of Disposition (Name of cematary, cramatory or other place) 20e. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-14-00 Baltimore, MD Metro Crematory Inc. 22. Name and Address of Facility
Cremation Society of MD, Inc. 21. Signature of Funarai Sarvice License Thomas Gregor 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, auch as cardiec or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final nevuonia 1 week disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner years. eneu hay attending physician and for use as the burial-transit be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseasa or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): P.O. Box 68760. Physician/Medical Dua to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown signed d be del Records, Be Completed by 24b. Were autopsy findings evallable prior to completion of cause of death? 24a. Wes an autopsy performed? Vencos tumbosis page 2 this certificate 1 Yes 2 TNO 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was casa raferred to medical 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) 20 1 Yes 2 -No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: After 5 Pending Invastigation 1 ANatural deeth. 1 Yes 2 No 2 Accident Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) after 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Fortifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.

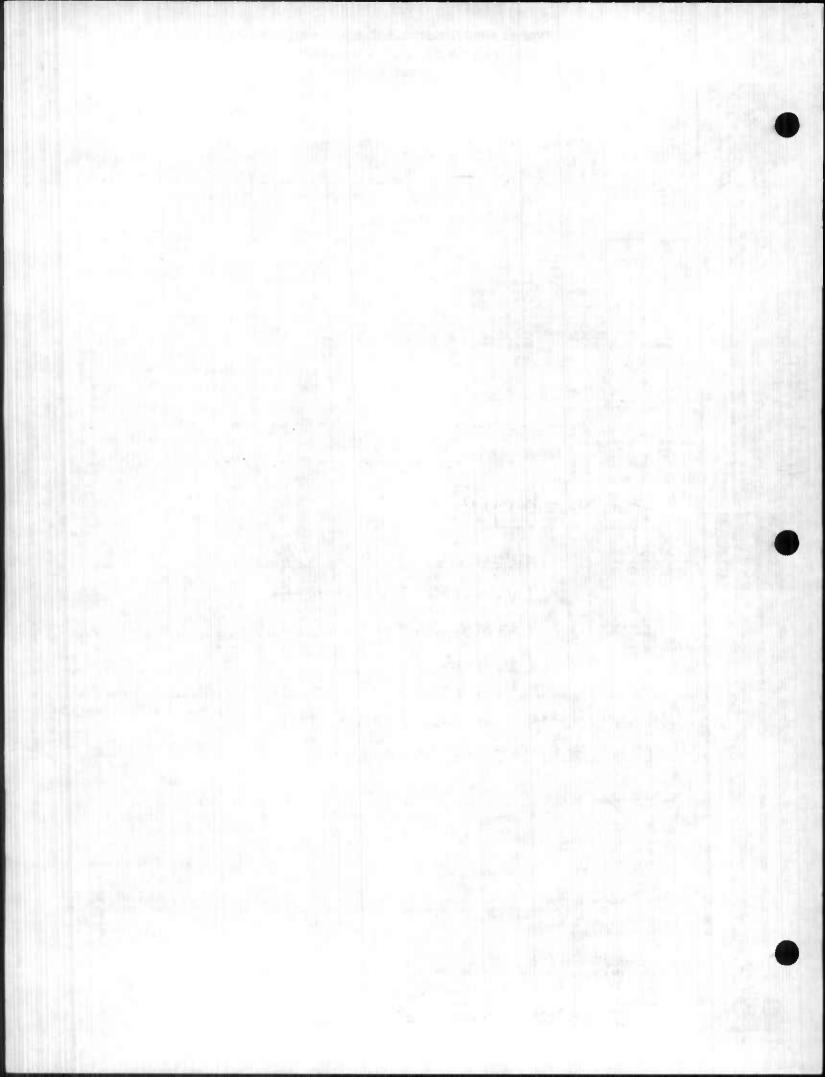
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of centific 29d. Date signed (Month, Day, Year) 29c. License number 66 2000-30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) 5743 Edmondson Avenue 21228 Catonsville, MD 31. Date filed (Month, Day, Year) 32. Registrar'a Signature State oaks Registrar SEP 9 2000

**DHMH 16 Rev 6/95** 



Physician	EM: #7 PER F	dle, Last)			, ~	2. Date of De	eath ; Day ; ,	Year 3. Time of	Death
/Medical	Erwin			Coo	k Jr.	Septen or Location of Deal	1PER 14, 21	000 Barp	m
Examiner	40 Facility Name (If not instituti Maryland Ge	neral Hosp	11		Baltme		th 4c. County of	of Death	
Funeral	5. Social Security Number	6. Sex 7. A	ge (In yrs. last birth	nday) If Under 1 Ye Months Da	ar If Under 24 h		rth av. Year)	9. Birthplace (State or Country)	Foreign
Director	220-12-2959	XXM 20F 75	76 Y	rs.	75 110015	07 0			
2	Usual Residence of Decedent  10a. State  10b. Count	ly	10c. City, Town	or Location				10d. Inside Cit	y Limits
al Director	MD NA		Balti	more				1 🌠 Yes	2 🗆 No
Director	10e. Street and Number			10f. Zip Cod	e		10g. Citizen of W	/hat Country?	
ral	1000 North				21217		U.S.		
Funeral	11. Merital Stetus	12. Wes Decedent Armed Forces	7	13. Was Decedent of If Yes, specify C	of Hispenic Origin? Suban, Mexican, Pu	(Specify Yes or No Jerto Rican, etc.)	o- 14. Race Black	e - American Indian, k, White, etc.	
by F	1 Never Merried 2 Me 3 Widowed 4 Divorce	If Yes, Give		1□Yes ¾☐	No Specify:		Specify:	Black	
		ent's Education nest grade completed)	16a. I	Decedent's Usual Oc	cupation	working	16b. Kind of Bu	siness/Industry	
Completed	Elementary/Secondary (0-12)		5+)	(Give kind of work do life. DO NOT use rel					
8	8th grade  17. Father's Name (First, Middle	na n. Last)	,	Constru	-	Name (First, Middle		uction Co	J.
To Be	Irvin H. Co				Cathe	rine Ca	rter		
-	19a. Informant's Name/Relation			Mailing Address (Str				_	1117
	Kassandra J	ackson-Dau							d
8	20e. Method of Disposition 1 ☐ Burjal 2 💆 Cremation		cemetery	Disposition (Name of crematory or other	place)	Date 10	The second second	City or Town, State	
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	Part Loler the disease, shoot or leart failure. Lis		ed the death. Do no	1				Approximate	
an	anose or pear failure. Cit	st only one cause on each	⊪ne. •					Interval Bety Onset and D	eath
al er	Immediate Chrise (Final disease or condition resulting in death)	. theun	noma						
وَ		Pandi	O VOSCUL	1	Islase				
Examiner	Sequentially list conditions.	b. Cara	Due to (or es a co				-9.1		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	ARte	rioscher	0515					
용	that initiated events resulting in deeth) Last	0 1	Due to (or as a co	onsequenca ot);					- 34
M		a Lach	exia						
Be Completed by Physician/Me	Part it. Other eignificant condit	tions contributing to death	but not resulting in	the underlying cause	given in Pert I.	23b. Dtd	tobacco uas con	ntributs to the cause of	of gleath?
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Jumo		5				1.5	Yes 2 No	of death?	No
Š -	25. Was case referred to medic	ai			26. Place of	Death (Check only		10 165 20	140
00	examiner? 1 Yes 2 No	Hospital: 1 1 tnpat	tient 2 ER/Out	patient 3 DOA	Other:	ng Home 5 ☐ Res		er (Specify)	
0	27. Manger of Death	28a. Date of Inj (Month, Di	ay Year) 28b. Ti	jury	njury at Work?	28d. Describe	how injury occurr	red	
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tlon: To	2 Accident Inves	stigation	njury - At home, fam etc. (Specify)	m, street, factory, offi	ice	28f. Location City or To	own, State)	er or Rural Route Num.	ber,
D die	2 Accident 3 Suicide 4 Homicide 6 Could deter	stigation	t of my knowledge, of examination and	death occurred at the	e time, date and p	City or To	own, State) e cause(s) and ma	nner as stated.	
tlon: To	2 Accident 3 Suicide 4 Homlcide  29a. Certifier (Check only 2 Medics	d not be 28e. Piace of In building, e 28e. The best al Examtner: On the basis of and manner s	t of my knowledge, of examination and	death occurred at the	e time, date and p	City or To	own, State)  e cause(s) and ma e, date and placa, a	nner as stated.	
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Medical Certification: To	2 Accident 3 Suicide 4 Homicide  29s. Certifier (Check only one)	d not be rmined 28e. Place of In building, e ring Physictan: To the best at Examtner: On the basis and manner ster	t of my knowledge, of examination and stated.	death occurred at the /or investigation, in m	e time, date and p ny opinion, deeth o	City or To	own, State)  e cause(s) and ma e, date and placa, a	nner as stated. and due to the cause(s	

DHMH 16 Rsv 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29428 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** Mariano Diforte, Sr. September 16, 2000 11:50 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare-Perring Parkway Center Baltimore Baltimore If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) August 27, 1911 9. Birthplace (State or Foreign **Funeral** Months Days 10M 20F Hours Italy 215-01-3664 89 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits ma 23a or 28a-f ahow must be notified at 1 Yas 2 No Director MD **Baltimore** Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or itema 23a or 21234 2820 Aspen Hill Road U.S.A. Funeral death 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental thygiene. art: If Itam 27 Is marked other than "natural", or Ne rry or other traumatic event, the Modes Issural in 1 ☐ Yes 2 🕅 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√ No Specify: Specify: White by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) Tailor 6 yrs. Clothing 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Meiden Sumame) Be Carmelo Diforte Anunzia Leonardo 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Michele Podolak-grandaughter 2820 Aspen Hill Rd., Baltimore, MD 21234 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removel from State permit. Page Department of Important: If any Injury or page. Gardens of Faith Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 9/20/00 Baltimore, MD 22. Name and Address of Facility Leonard J. Ruck Funeral Home, Inc. 21. Signature of Funeral Service Licensee William G. Dau 5305 Harford Rd., Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete fnterval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Examiner Mate Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) physician s the burial P.O. Box 68760, Physician/Medical Due to (or es a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Dfd tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably A Unknown Records. Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy 1□ Yes 20 No 1 Yes 2 No Division of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Placa of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatlent 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Netural 2 Accident 5 Panding investigation To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: After completely filled in by the fur 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARTHA EMMUNY 3007 & Northern Parkury Ealtimne

DHMH 16 Rev 6/95

State

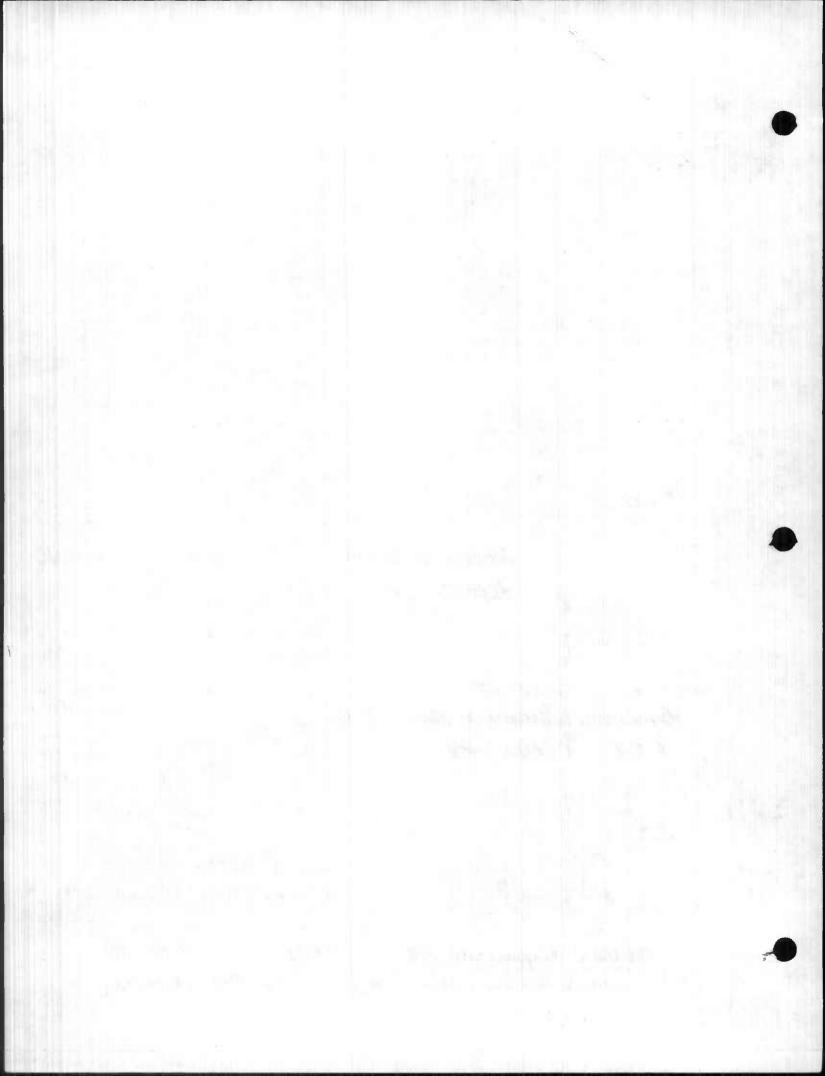
Registrar

31. Date filed (Month, Day, Year)

SEP

32. Registrer Signeture

1.9 2000



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 17,2000 1:25pm Ethel Lorraine Dowling 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Reisterstown FutureCare at Cherrywood If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 M 2 F 80 Yrs. 1920 Cumberland, MD 219-14-7060 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits York Hanover 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 17331 804 Baltimore St. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Merried Specify White 1 Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Manufacturing Packer 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Mary Magdelene Weaver Charles Leonard Moore 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 58 N. Queen Street, Littlestown, PA 17340 Herbert G. Dowling, Sr. Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete Nation 2 □ Cremetion 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/21/00Qumberland, MD Hillcrest Cemetery 21. Signeture of Funeral Service Ligensee 22. Name end Address of Fecility 11824 Resterstown Rd. KIRWIG Eline Funeral Home Reisterstown, MD 21136 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear feilure. List only one cause on each line. Approximate Intervel Between Onset and Deeth bronth Immediate Cause (Finel disease or condition resulting in death) stera eri phera Due to (or as a conse 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one)

**Physician** /Medical Examiner

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certificate

Be

Certification: To

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Hospital or Attanding Physician:
 24 hours after death.
 Funeral Director: After this certifical ethy filled in by the funeral director;

To the Hosp within 24 hou To the Fune completely fi

the death certificate be axecuted

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a. Stata

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Director

Funeral

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Completed

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**Funeral** 

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pernit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hyglene. Important: if Item 27 Is marked other than "natures", or he eny Injury or other traumatic event, the Medical Example

Baitimore, Maryland 21215-0020

the Madical Examiner must be notified at

with the Manyland

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last Physician/Medical þ Completed

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

, mod 157. [M. PANSURIYA

25. Was case referred to medical axaminer? 1 Yes 2 No 1 Netural 2 Accident

28a. Date of Injury (Month, Day Year) 5 Pending investigation

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Tima of

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

281. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 ☐ Suicide

4 ☐ Homicide

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Dete signed (Month, Day, Year)

29b. Signature and little of certifier

6 ☐ Could not be

31. Date filed (Month, Day, Year)

30. Name and eddress of person

completed cause of death (Item 23a) (Type, Print)
MDR, Weston Inster 32. Registrar's Signeture

SEP 19 ZUUJ

**DHMH 16 Rev 6/95** 

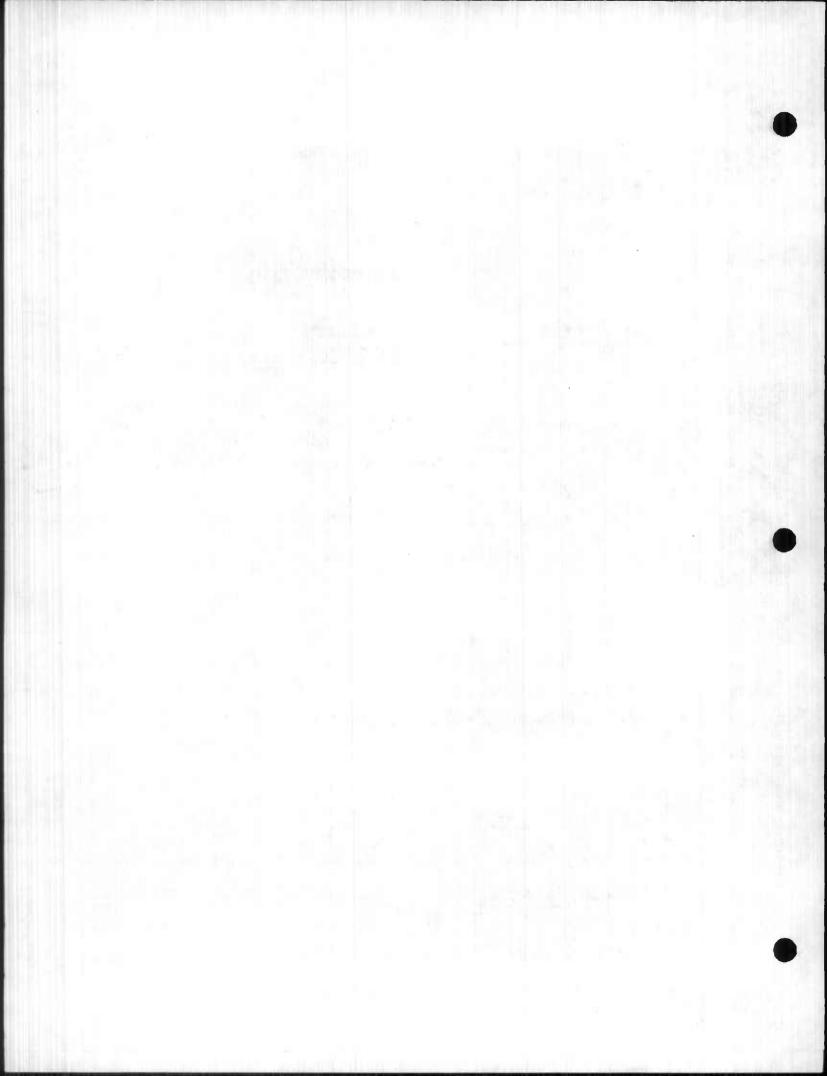
Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** MARIE 6. ENgle September 17, 2000 8:00 a.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Care Center Baltimore Co. Parkville 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Days 213-20-5789 76 Director Maryland Usual Residence of Decedent 10c. City. Town or Location 10h. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 Yes 2 No Director Maryland Baltimore Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 8832 Walther Blvd. #210 United States Berns 23a 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0020 natural, or 1 Yes 2 No Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 Important: if hem 27 is marked other i any injury or other traumatic event, III anse. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Olevanti Marie Ruta Moriconi 19s. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. Robert L. Engle 162 Lake Ridge Road Southbury, CT 06488 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 9/20/00 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Michael E. Canapp LEONARD J. RUCK, INC. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Parkinson's years Examiner Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): physician the burial Box 68760. Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 PNo 3 Probably 4 Unknown Cerebral Vascular Academs, Hypertenson, Division of Vital Records. Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? 8 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 27. Manner of Death Hospital or Attending Pi
 24 hours after death.
 Funeral Director: After the 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkville, Md 21234. State

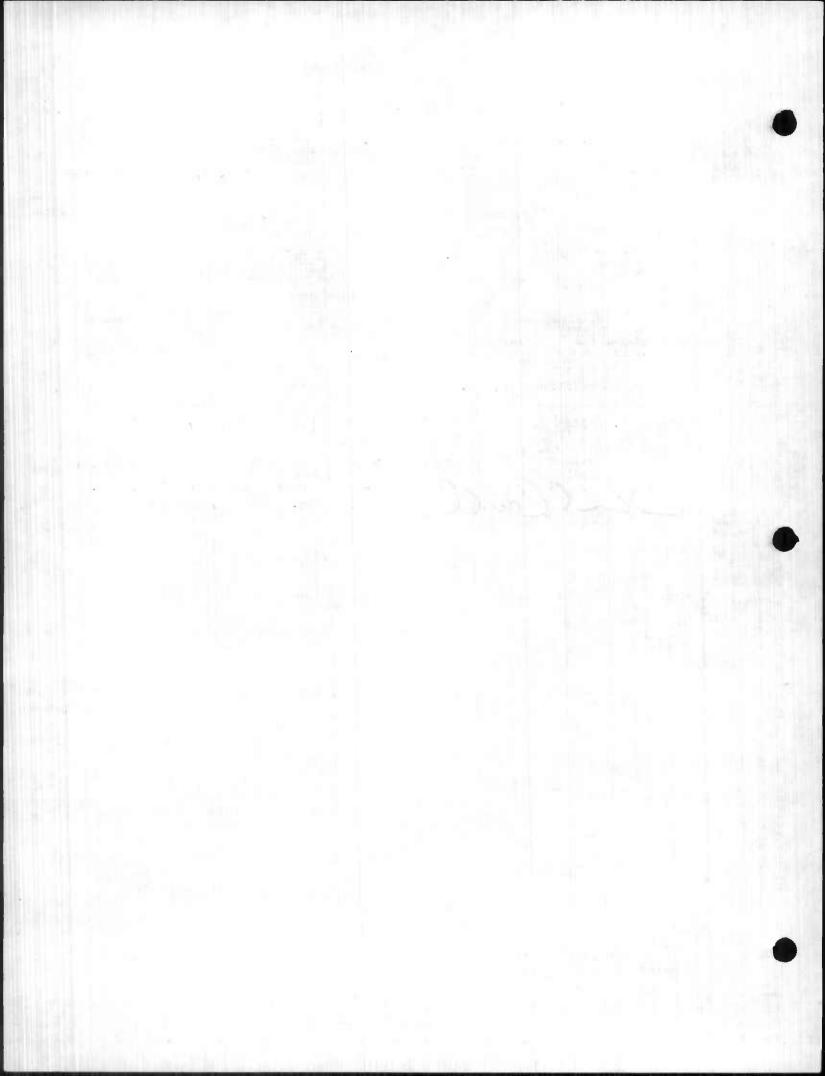
**DHMH 16 Rev 6/95** 

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10 45 Ruth Eckhart 2000 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltmork Genesis Heritage Meridian Eldercare Ctr. Dundalk 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□ M 2☑ F 213-20-8207 Director 75 Aug. 4,1925 Maryland Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c City Town or Location 10d. Inside City Limits 28s-f show must be notified at Maryland Baltimore Dundalk 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 2903 Dunglow Road 23a Apt. 1 21222 United States Funeral Rema ; Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. 72 hours after Yes 2 No f Yes, Give 1 Never Married 2 Merried 8 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify Completed by 3. Widowed 4 □ Divorced Year or Dates "natural". White 16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Years Receptionist Clerical Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Pages 1 and 2 should be finent of Health and Mental I int: If them 27 is marked or James Henry Livingston, Sr. Mamie Anna Johnson 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) 7031 Mac Beth Way Sykesville, MD 21784 Ronald B. White (Son) other 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 6 1 ☑ Burlei 2 ☐ Cremetion 3 ☐ Removel from Stete Department of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore National Cemetery 9/21/2000 Baltimore, MD 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maj death. Do not enter the mode of dying, such as cardiac or respiratory arrast Dundalk, Maryland 25a. Part1. Enter the disease, or complications that caused the shock, or heart feilure. List only one cause on each line. Approximata Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final CIRRHOSIC diseese or condition resulting in deeth) Examiner Examiner BN COPHALO ATIC The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest NON DEPENDEMT DIABETES MEWINS Box 68760. INSULIA Physician/Medical the Due to (or es a consequence of) PHIMOMARY MRONIC OBSTRULTIVE for use signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records, Be Completed by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 No certificate Division of Vital Attending Physician: 25. Wes case referred prinedical axaminer? funeral director. 26. Place of Death (Check only one) Hospifel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 | Yes 2 | 1 | No 2 ER/Outpetient 3 DOA this 27. Menner of Death 28a. Dete of Injury (Month, Dev Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Naturel 5 Panding investigation 1 Yes 2 No 2 Accident within 24 hours after death. To the Funeral Director: A 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide 8 Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. Medicai 29e. Certifier completely (Check only one) \$ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 50 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Worler sertli nee 31. Dete filed (Mo 32. Registrat's Signeture State Registrar

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nema (First, Middla, Last) 2. Data of Deeth 3. Time of Death **Physician** Month Yaar Irene M. Erickson 09 15 2000 3:15AM /Medical 4e. Fecility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COCKEYSUILLE

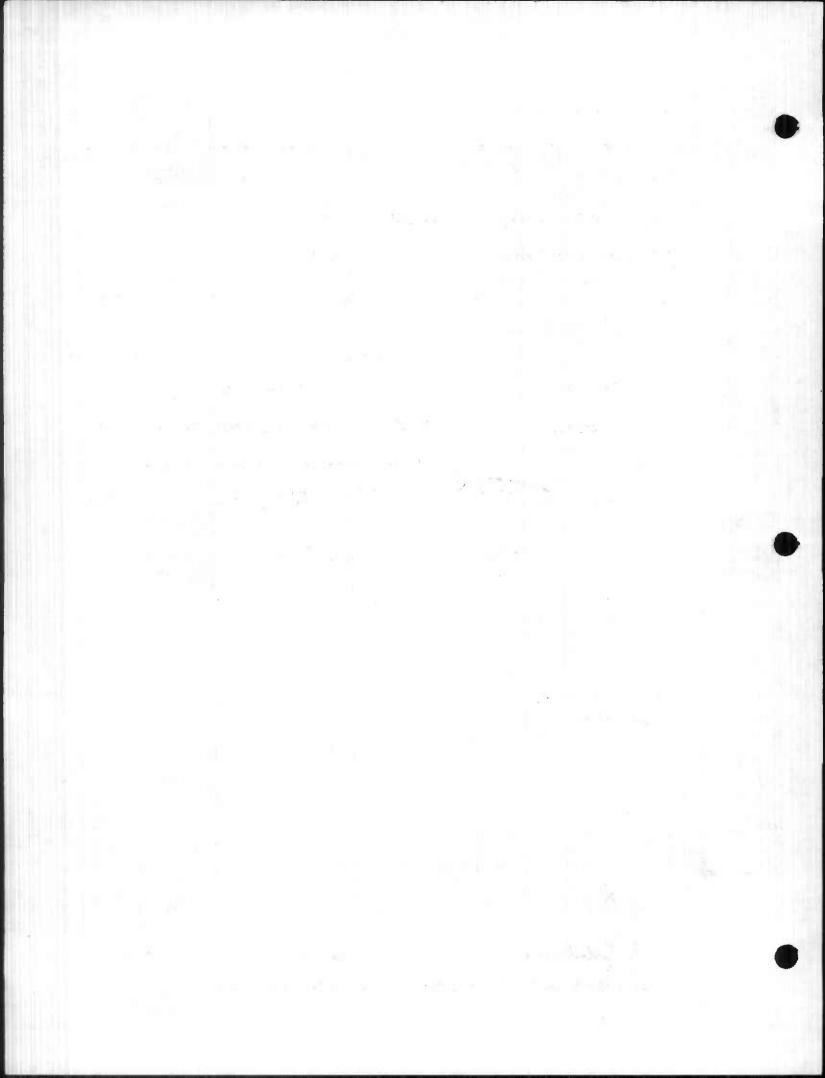
If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) Maryland Masonic Homes Baltimore 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 1□M 20XF **Funeral** Yrs. 02/06/1908 Director 473-12-3876 Usuai Rasidance of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examiner must be notified at Director 1 Yes 2 No MD Prince Georges Beltsville the 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 11409 Hennessey Drive USA 20705 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Rece - American Indian, Black, White, atc. 72 hours after 1 Yes 2 No If Yas, Give X Year or Datas: 1 Never Merried 2 Marriad Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elamantary/Secondary (0-12) Collega (1-4or 5+) permit, Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If Item 27 Is marked other thy any injury or other traumatic event, the once. Nursing Health Care 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be Ludwig Peterson Sarah Kotz 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 11409 Hennessey Dr., Beltsville, MD 20705 Roger Engstrom/Son 20a. Mathod of Disposition

1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stata 20b. Place of Disposition (Name of cematary, crematory or other place) 20c. Location - City or Town, Stata 4 ☐ Donation 5 ☐ Othar (Specify) Hazelwood Cemetery 9/18/00 | Bayport, MN 21. Signature of Funarai Service Licensee 22. Neme end Addrass of Fecility Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093 Michael J. Flagte 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Betw **Physician** /Medical tmmediata Causa (Final diseasa or condition rasulting in daath) ATher Schoter VASCular Dylas Examiner Dua to (or as a consequence of) attending physician and for use as the burlal-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadieta cause. Entar Underlying Cause (Disaese or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of) P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? t Yes 2 No 3 Probably 4 Onknown amertin. signed b Records, Completed by 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? peeu page 2 1 Yas 2 No 1 Yas 2 No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; 25. Was casa rafarred to medical axaminar?
1 Yas 2 No Be 28. Place of Death (Check only ona) Other: Nursing Homa 5 Rasidance 8 Othar (Specify) Medical Certification: To 1 Inpatlant 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? 5 Panding Investigation 1 SNatural 1 Yas 2 No 2 Accident 3 Sulcida 6 Could not be datarmined Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner stated. 29a. Cartiflar 29b. Signetura end titla of certifiar 29c. License number 29d. Dete signed (Month, Day, Year) 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) ROSERT LIBERTO, BALTO, and 212 Ly 3108 BANK ST MD. 31. Data filed (Month, Day, Year) 32. Registrads Signatura State

Registrar

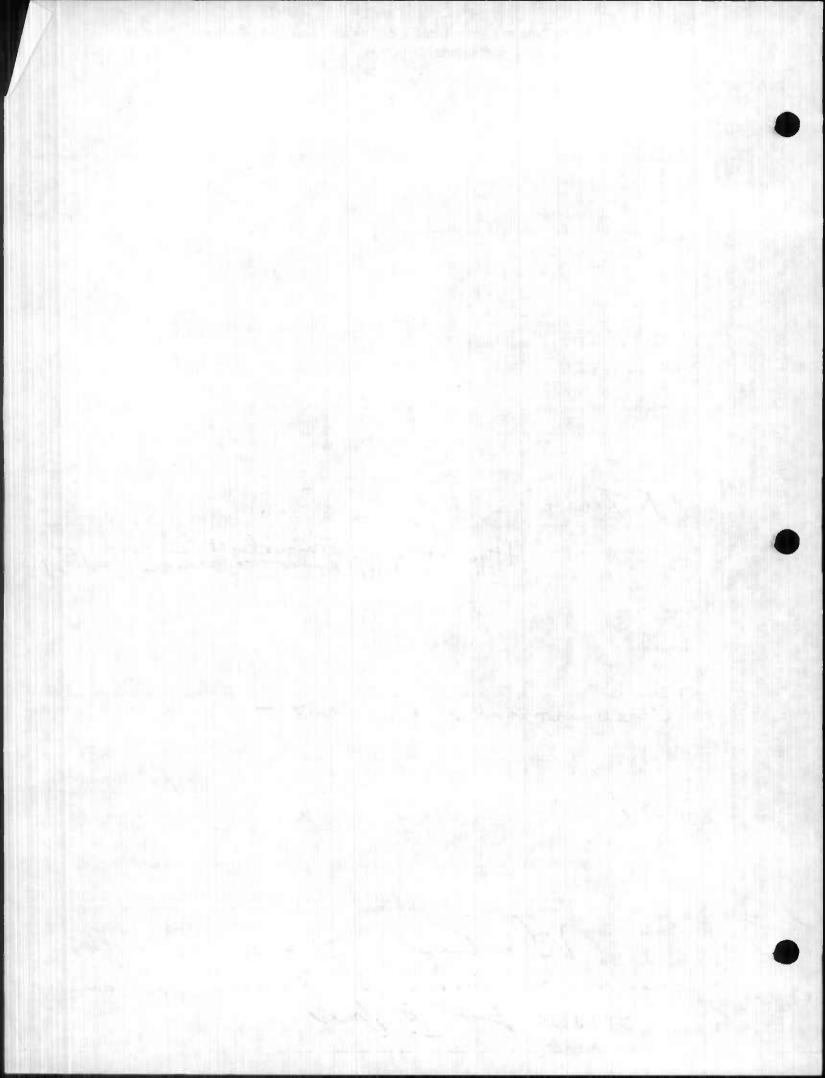


State of Maryland / Department of Health and Mental Hygiene 00 29433

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Physician /Medical		me (First, Middle, La		HAZEL I	R F	LANAG				2. Date of De Month SEPT •	Day 18 2	Year 000	3. Time of Death 8:28am	
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Funeral Director	5. Social Security 219–30–	0098	Sex 1 □ M 21X F	7. Age (In yrs. last 88	Yrs.		ays	Hours	Min.	8. Date of Bir (Month, Da Dec • 2	v. Year)	9. Birthp Cour. PA	place (State or Foreign htry)	
9	Usual Residence	10b. County		10c. City, T	own or Lo	cation						1	I Od. inside City Limita	
teath with the Maryla ma 23e or 28e-f shor must be notified at sersi Director	MD	Baltim	ore					sex					1 ☐ Yes 2 🖾 No	
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The state of		rried 2 Married	Armed Ford  1 Yes  If Yes, Give  Year or Da	200 No		f Yes, specify (		Specify:	i, Puerto	ecity Yes or No Rican, etc.)	Bla Specia	ck, White,		
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Maryland d 2 should be file th and Mental Hy 7 is mericad othe traumatic event		Name/Relationship (		1	19b. Mailir	ng Address (St	reet a				er, City or Town		Code)	
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Baltimore, omit. Pages 1 a bepartment of Has moortant: If Nem ny Injury or othe nice.	20a. Method of Disposition  **EXBurial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  GArdens of Faith  9/21/2									Date 21/2000	20c. Location Rossvi		MD.	
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0 88188	D R	Topic	16		1		_				of Essex			
-	23a. Part 1. Enter	the disease, or com	lications that ca	used the death.	o not ent	er the mode of	ACE dying	, such as	cardiac	1timore or respiratory a	MD 21	221	Approximate Interval Between	
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/Medical	Immediate Cause	(Final	H	yperx	ferra	we.	al	her	200	dis			15 42	
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S, P.O. ss that the degreed by the sbe detached by Physic	Part II. Other aign	ficant conditions	contributing to dea	ath but not resultin	g in the u	nderlying caus	e give	n in Part I	,		Yan X No	3 □ Pro	o the causa of death?	
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Of Vital I Physician: The this certificate ral director, page 1. To Be Co	25. Was case refe exeminer?	erred to medical	Hospital:				Otho		of Deat	th (Check only	one)			
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C Page Co	27. Manner of Dea	5 Pending		n, Day Year)	b. Time of Injury	M 28c.	Injury Work	es 2 □	No	280. Describe	how injury occu	rred		
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polital ours filled	29a, Certifier	Certifying Pt	vaician: To the b	pest of my knowled	doe, death	occurred at th	ne tim	e. date an	d place.	and due to the	cause(s) and m	anner as s	stated.	
Division o To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	(Check only one)	2 Medical Exam	minar: On the bas and mann	sis of examination	and/or inv	estigation, in i	my op	inion, dea	th occur	red at the time,	date and place	, and due to	o the cause(s)	
Within To the comp	29b. Signature and	d little of ced for	1//	1		29c. Li	cense	number		,	29d. Date sign	ed (Month,	Day, Year)	
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I,	30. Nama and add	dress of person who	completed cause	of death (Item 23	a) (Type,	Print) WA	0	SM	GK	TUHAN	< 1	0	L	
	31. Date filed (Mo	nth Day Veerl	32 Ba	istrer's Signeture		40	_	٥	7	ou	B	all	21221	
State Registrar		SEP 1 9 20	000	Personal Signature	19.	Low	Ks	1					-/	

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DHMH 16 Rav 6/95



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29434 Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) **Physician** 09-16-2000 FARMER 10:40PM ROSA T. . /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HCR-MANOR CARE If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day Year) 08-23-1914 Birthpleca (State or Foreign Country)
 NC 5. Social Security Numbar 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours Min 1□ M 21 F 86 217-01-6789 Yrs. **Director** Usual Rasidenca of Decadant death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at YN Yas 2 □ No BALTIMORE Director MD N/A 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Number 21216 USA 3509 SPRINGDALE AVENUE Funeral 12. Was Dacadant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health end Mentel Hygiena. Important: if Item 27 is marked other than "naturel", or ite any Injury or other traumatic event, tre Medical Exertines once. 1 ☐ Yas 2 ☐ No If Yas, Giva X Yaar or Datas: 1 Navar Married 2 Married BLACK altimore, Maryland 21215-0020 1 Yas 2 No Specify: by 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Dacedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry 5 College (1-4or 5+) Elementery/Secondery (0-12) EDUCATION TEACHER 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumema) Be ROSETTA ROBERT COFIELD To 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straaf and Number or Rural Routa Number, City or Town, Stata, Zip Code) 3509 SPRINGDALE AVENUE BALTO., MD. 21216 LOUISE WILLIAMS/DAUGHTER 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Steta 20a. Mathod of Disposition 1 X Burial 2 □ Cramation 3 □ Ramoval from Stata WESTERN STAR 9/22/200 BALTO., MD. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funaral Sarvice Licensaa 22. Nama and Address of Facility JAMES A. MORTON & SONS F.H., INC Part Entar tha disaasa, or complications that causad tha death. Do not antar the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Intarval Batween Onset and Death **Physician** Cancer Breat Immediate Cause (Final disaasa or condition rasulting in daath) /Medical Examiner Due to (or as a consaquanca of) Examiner ician and buriel-transit the death certificate be executed Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarfying Causa (Diseasa or injury that initiated avants rasulting in daath) Last Due to (or as a consequence of): physician s the buriel Box 68760 Physician/Medical Dua to (or as a consequence of) 89 use ( for P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown signed t Division of Vital Records, by 24b. Wara autopsy findings available prior to 24e. Was en eutopsy performed? Completed completion of cause of death? page 2 s hes 1 Tyes 2 No 1 Yas 2 TNO certificata or Attending Physician: funeral director, 25. Was cese referred to medicel axaminar?
1 Yas 2 No 26. Place of Deeth (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of After 1 Natural 5 Pending death. 1 ☐ Yas 2 ☐ No invastigation 2 Accident 4 hours aftar death 6 ☐ Could not be datamined 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) filled in by 4 Homicida Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and mannar es stated.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and mannar stated. 29a. Certifier edicai (Check only one) To the F 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and litia of certifiar 2000

ARMORY Pl. BAlto, MD. 21201

State Registrar

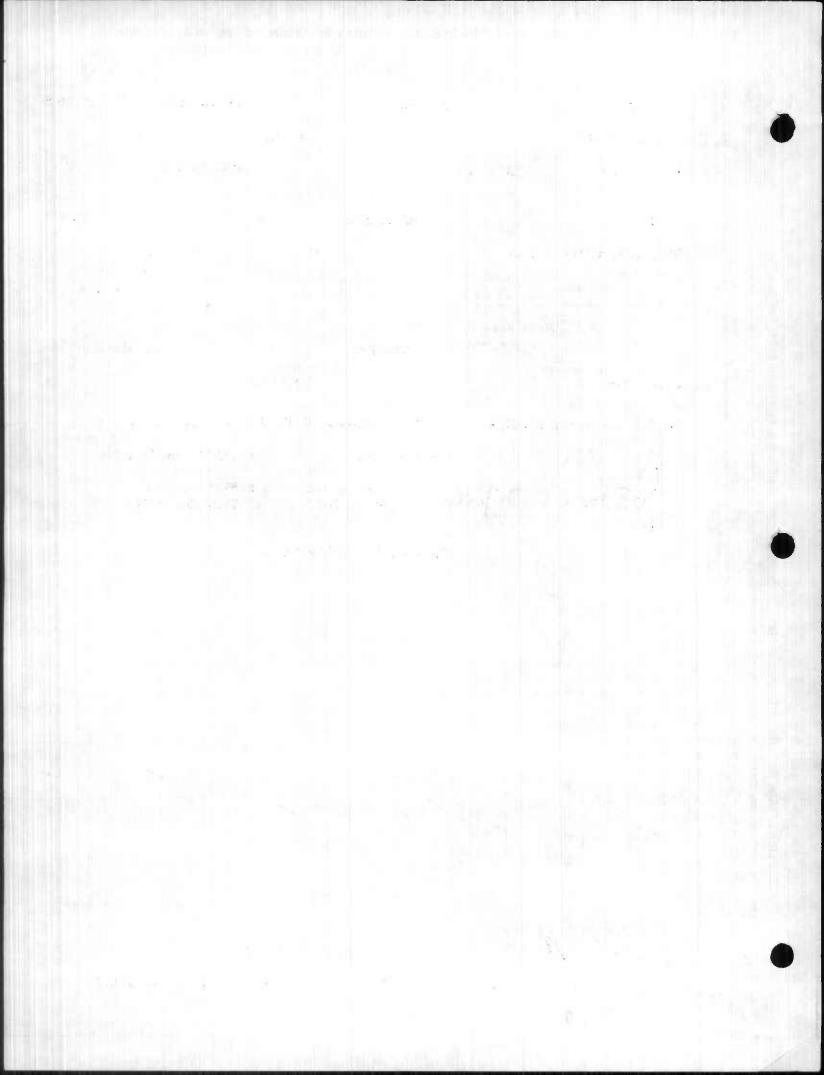
31. Data filed (Month, Day, Year)

30. Nama and address of person who completed causa of daeth (Item 23e) (Type, Print)

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32. Registrar's Signatura

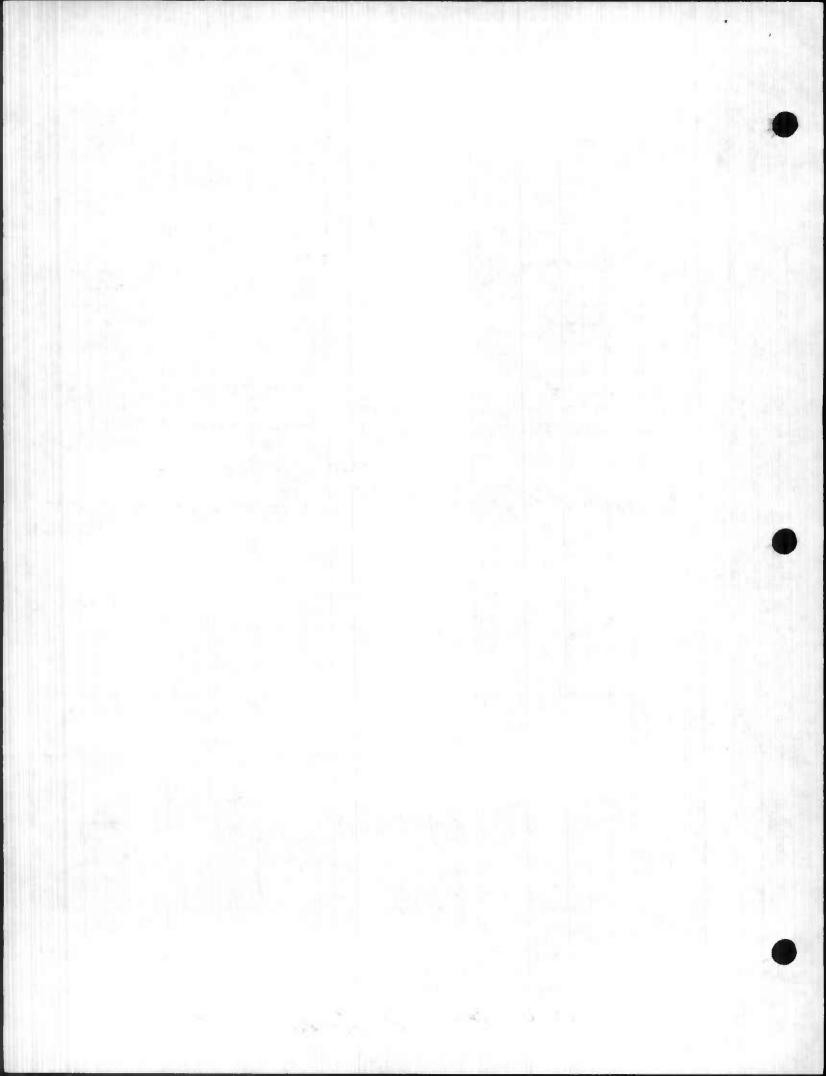


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Golder **Physician** 04-48 A utumi Septeniber 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Nama (If not institution, giva street and number) Examiner Battimore City HOPKINS OSPITA 8. Date of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) If Under 1 Yaar | If Under 24 Hrs. Birthpieca (Stata or Foreign Country) 5. Social Security Number (4N) 6. Sex **Funeral** Months Days Hours 1 M 2 XF Yrs Director August 29, 1997 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. fnside City Limits 10b. County or 25a-f show 1⊠Yes 2□ No Baltimore Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 238 21217 Funeral 2066 Linden Avenue USA 12. Was Decedent Evar in U,S.
Armed Forces?
1 □ Yas 2 ☑ No
If Yes, Give
Year or Dates: 14. Race - American Indian, Black, Whita, etc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No ff Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status 1 Never Married 2 Married African à Baltimore, Maryland 21215-0020 1 Yes 2 No by 3 Widowed 4 Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) NA NA NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be next of Health and Mental ant: If them 27 is marked of Sherry Wilson Donta I. Golder 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sherry Wilson-Williams 2066 Linden Avenue Baltimore, MD 21217 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 DBurlal 2 Cremation 3 Removal from State 4 □Donation 5 □Other (Specify) 9/20/00 Baltimore, MD Woodlawn Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home PA 638 N. Gilmor Street Baltimore, MD 21217 23a. Part1. Enter the diseasa, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or raspiratory arrest abock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical fmmediate Cause (Finel disease or condition resulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be execu ears Biliarl Box 68760, Due to (or as a cons USB 85 P.O. Part II. Other signiffcant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 20 of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was en eutopsy 200 No 210 No 1 Yes 1 Yes To the Hospital or Attanding Physician: 25. Was case refarred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Menyler of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Division 1 Natural 5 Pending Investigation s after deeth. 1 Yes 2 🗆 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and mennar as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29d. Data signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. Licanse number KES. OO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD Blatock 904 Elizabeth Tohns Hopkins 32. Registrar'a Signature State

DHMH 16 Rev 6/95

Registrar



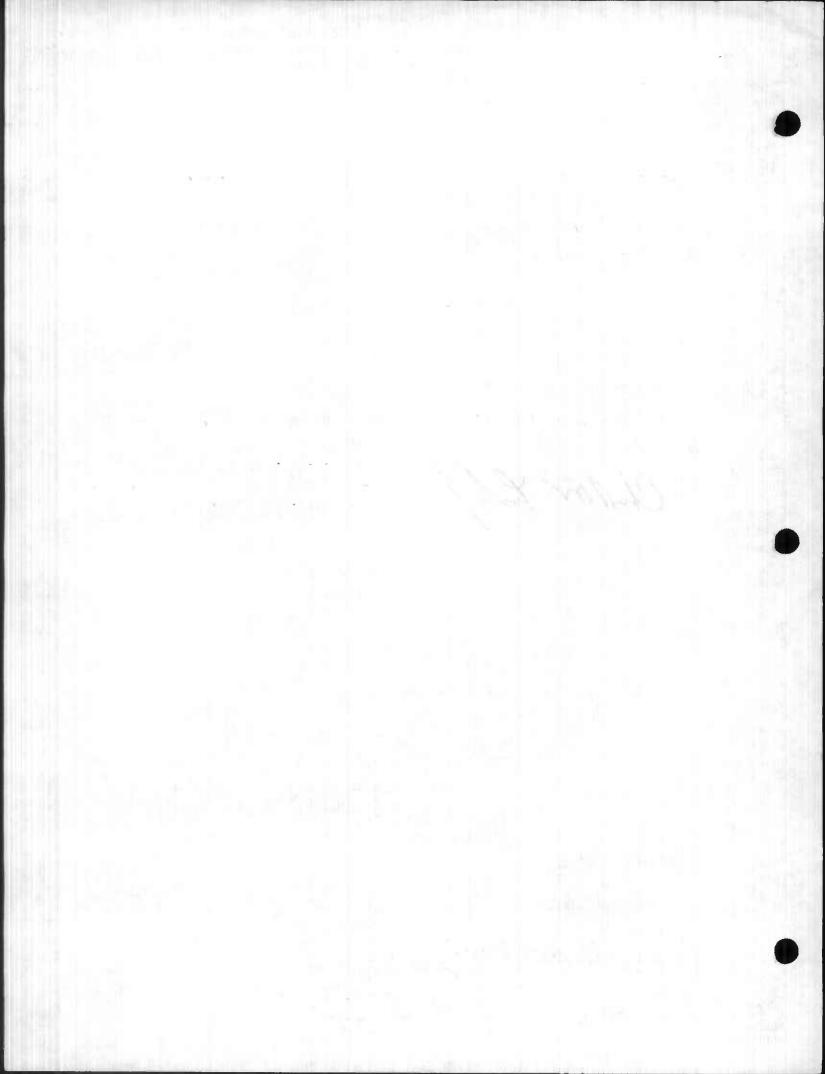
00-5194-510 RICHARD GRAY

#### Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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mend item	23a,2/,28a,b,c,d,e,f,	per me G/8.	/ 9/25/00 y	Certifica	te of	Death		Reg. I	No.		2700	
Physician /Medical	Decedent's Name (First, Middle, L		l Scott G	ray			2. Date of Month	1 [	Day 13,20	Year 00 0	3. Tima of Death 4:56 A.N	
Examiner	4a Facility Nama (If not institution, g	iva street and numbe	r)			4b. City, Town,	or Location of	Death	4c. County of	of Death		
	JOHNS HOPKINS BA	AYView HOS	PITAL			Baltimo			N/	'A		
Funeral Director	213-76-9565	Sex 1⊠M 2□ F	Age (In yrs. last birt	hday) If Unde Months	Days		Ain. (Mont	of Birth h, Day, Yea			ce (State or Forei y) 11and	
100	Usual Residence of Decedent  10a. Stata 10b. County		40- City Town	ast sestion						100	d. Inside City Limi	
a dat	Toa. Stata Too. County		10c. City, Town	or Location						100	1 ☑ Yes 2 ☐ N	
or 28a-1 s be notified Directo	Maryland N/A					Ва	ltimore					
Dir.	10e. Street and Number			10f. Z	ip Code			10g.	Citizen of W	hat Country	y?	
	1537 Elrino St	reet				21224			nited			
iner mat iner mat Funeral	11. Marital Status	12. Was Deceder Armed Forces	5?	13. Was Deci	edent of ecity Cu	Hispanic Origin ban, Mexican, P	? (Specify Yas uerto Rican, etc.	or No-		- American , White, et		
by Ev	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∑ Yas 2 ☐ If Yes, Giva Yaar or Dates	:1979 <b>-</b> 81	1 🗆 Yes	2 <b>2</b> No	Specify:			Specify:	<b>V</b>	White	
t. the Medical Completed	15. Decedent's I		169.	Decedent's Us	ual Occu	pation a during most of	working	16b	. Kind of Bus	siness/Indu	stry	
The state	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life. DO NOT	use retir	ed)	Working					
2 5	12 Years			Machin	e Or	perator		1	Manufacturing			
0 4 G	17. Fethar's Name (First, Middle, Las	st)				18. Mother's	Neme (First, M	liddle, Meid	len Sumame	9)		
To E	John Clyde Gra	У				Dorot	hy Berr	nadet	te Car	ter		
	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Addre	s (Stree	et and Number o	r Rural Route f	lumber, Cit	ty or Town,	State, Zip C	Code)	
	Trudy Ann Nade	au (Sister	2) 7	401 Eds	wort	th Road	Dunda:	lk, Ma	arylar	nd 21	1222	
16	20a. Method of Disposition		20b. Place of	Disposition (N	ama of	****	Date	20c	Location -	City or Tow	m, Stata	
ury or	Burial 2 Cremation 3 4 Donation 5 Other (Spec		8	on Fore		v.A.Cem.	9/19/2	2000	Owing	s Mil	lls, MD	
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1 2 8	1/1/1000	- tout	1//			e Ave.					222	
	23a. Part1. Enter the diseasa, or co- shock, or heart failure. List on	mplications that caus	of the death. Do n	ot enter the mo	de of dy	ing, such as car	diac or respirat	ory arrest,		1 !	Approximate Interval Between	
ial-transit Examiner	resulting in death)	b	NHALATION  Due to (or as a of									
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the att	Part II. Other algnificant conditions	contributing to death	but not resulting fr	the underlying	cause ç	jiven in Part I.	23b	Did tobac	co use con	tributs to	the cause of dear	
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page 2								4 50 Van	o 🗆 No	, rhe		
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ctor: A y the fu ficati	2 Accident investigati	on 7,23,00	unkr	IOMII W	1[	☐ Yes 2 <sup>2</sup> /2 <sup>2</sup> No						
al Director: After t led in by the funera Certification:	3 Suicide 6 Could not determine	d Zoe. Flace of	Injury - At home, fa etc. <i>(Specify)</i>	rm, street, facto	ory, office	9	City	or Town, S	tand Numb tele) 1537 ity, Ma	Elrin	Route Number, o Street	
To the Funeral Discompletely filled in Medical Cer		Physician: To the besiminer: On the basis and manner	of examinetion en									
Me Me	29b. Signature and title of certifier			2	9c. Lice	nse number		29d.	Date signed	d (Month, D	Dey, Year)	
- 8	11-10	1 21	1-		0.0	C.M.E.			PTEMBE			
1	30. Name and address of person wh	o completed cause o	death (Item 23e)	M, P. Type, Print)				.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			2000	
1		Ladenta	~		ree	t, Balti	more. N	/arvl	and 21	201		
State	31. Date filed (Month, Dev, Year)		rar's Signature	)	-	-		1 -		- V.S.		
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State of Maryland / Department of Health and Mental Hygiene

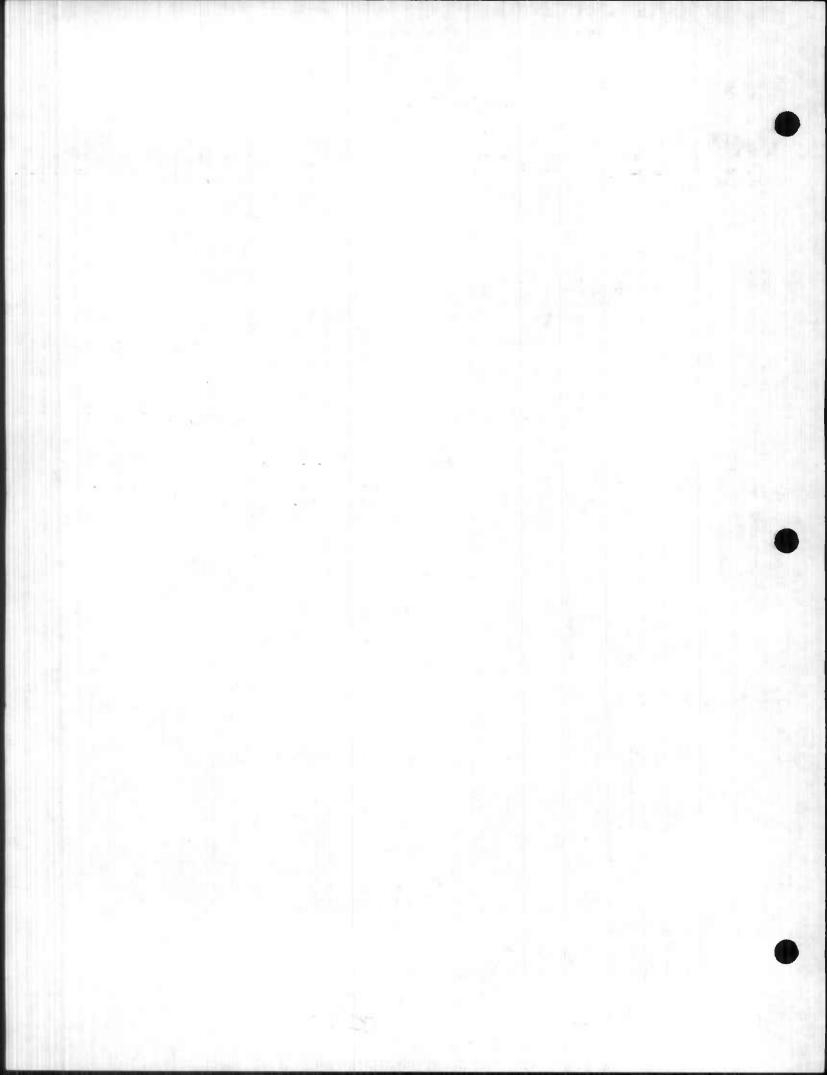
00 2943

ASP

Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3 Time of Deeth **Physician** 15 2000 Mary Louella Gray SEPTEMBER 12:33 P /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAYVIEW HOSPITAL BALTIMORE N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2⊠F Yrs. Georgetown, D.C 216-54-5430 48 Director May 8, 1952 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inaide City Limita Nerns 23s or 28s-f show the Maryla Baltimore City Yea 2□No Director Maryland N/A of Hygiene. Johns than "nebural", or Heme 23s or 28e-r event, the Medical Examiner must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of Whel Country? 21224 United States 1537 Elrino Street Funeral be filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Deceden! Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Specify: À 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Metro Food Markets Cashier 12 Years 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Mental marked Emmett Mullen Elizabeth Dixon 19b. Mailing Address (Streat end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Pages 1 and 2 s ment of Health an Ħ Elizabeth Campbell (Daughter) 1770 Melbourne Road Dundalk, Maryland M Health Rem 27 important: If the any injury or oth 0000 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremetion 3 Removal from Stele Garrison Forest V.A. Cem. 9/19/2000 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, the mode of dying, such as cardiac or respiratory errest, and or heart failure. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Cause (Finel disease or condition resulting in deeth) SMOKE INHALATION / THERMAL INJURIES Examiner Due to (or es a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed as the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury pue Due to (or es e consequence of) Box 68760. ate has been signed by the ettending physician page 2 should be detached for use as the buria that initieted events resulting in death) Last Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 XYes 2 No 3 Probably 4 Unknown of Vital Records, Be Completed by 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24e. Was an autopsy performed? After this certificate has 1 ☐ Yes 2 ZNO 1 □ Yas 2 □ No To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifical completely filled in by the funeral director; I 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Nopatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 No 2 No Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Division 5 Pending investigation victim of house fire 1 Neturel 9-13-00 1 Yes 2 No 407AM 2 X Accident 281. Location (Streat end Number or Burei Route Number, City or Town, Stete) 15 35 Elrino Rel 3 Suicide 6 Could not be determined 28e. Plece of Injury - Al home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide home Baltimore, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and pleca, and due to the ceuse(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) Medical 29a, Certifier and menner stated. 29d. Dete signed (Month, Dev. Year) 29b. Signeture and title of certifier 29c. License number O.C.M.E SEPTEMBER 15,2000 huter 30. Name and addrass of person who completed cause of deeth (Item 23a) (Type, Print) Chute 111 Penn Street, Baltimore, Maryland 21201 Dennis ans, 31. Dete filed (Month, Day, Year) 32. Registrer's Signature **State** SEP 1.9 2000 Zener Registrar



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29438 Certificate of Death 3. Tima of Death 2. Date of Death 1. Decedent's Nama (First, Middla, Last) 15 Day **Physician** 2000 Marvin M. Garrison, Sr 1:15 a.m. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Caton Manor Baltimore 6. Sex M2 M 2□ F If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours 57 Yrs. Md 217-40-3012 Director Usual Rasidance of Decedant the Maryland 10a Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 28a-f ahov traumatic event, the Medical Examiner must be notified at 1) Yes 2 No Director Md N/A Baltimore 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Number Nerna 23a or . 620 Linnard Street 21229 US A Funeral death 12. Wes Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Yaar or Datas: 14. Rece - American Indian. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Bleck, White, atc. filed within 72 hours after 1 Never Merried 2 Merried Saitimore, Maryland 21215-0020 "natural", or 1 ☐ Yas >XNo Specify: Black Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Unk than Elemantary/Secondary (0-12) Collega (1-4or 5+) Unk 12th grade N/A 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middla, Meidan Sumama) Be Pages 1 and 2 should be fit ment of Health and Mental Hant: If Itam 27 Is marked oth Pearl Willis Robert N. Garrison 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Steta, Zip Code) permit. Pages 1 and 2 Department of Health as Important: If Itam 27 Ia any Injury or other trac Phyllis A. Garrison- Wife 620 Linnard Street Baltimore, Md 21229 20b. Place of Disposition (Name of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 Cremation 3 Ramoval from State King Memorial Park 9-20-00 Randallstown, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licansee 22. Name and Address of Facility
March F/H West 21215 4300 Wabash Avenue BALTIMORE, 23a. Pert1. Entar the disease, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Betwaan Onsat and Death **Physician** /Medical Immediata Causa (Final diseasa or condition rasulting in death) Examiner es e consequança of): Physician/Medical Examiner umonia The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): and use as the burial-tran Box 68760. attending physician Due to (or es e consequenca of): 23h. Did tohacco use contribute to the cause of death? P.O. be detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 94 been signed by 1 TYes 2 No 3 Probably 4 Whiknown by of Vitai Records, ipital or Attanding Physician: The law require ours after death.

west Director: After this certificate has been signified in by the funeral director, page 2 should it filled in by the funeral director, page 2 should it 24b. Wara autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Be Completed 1 Yes 2 No 1 Yes 2 No 26. Placa of Daath (Check only one) Othar: 4 Nursing Homa Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Rasidence 6 ☐ Other (Specify) Medical Certification: To Injury at Work? 28d. Describe how injury occurred 28b. Tima of 28c. 5 Pending investigation Division 142 Natural Injury 1 Yas 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, offica building, atc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29e. Cartifiar 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to the cause(s) and mannar es stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatura and titla of certifiar 29d. Dete signed (Month, Day, Year) 29c. Licansa number

Registrar

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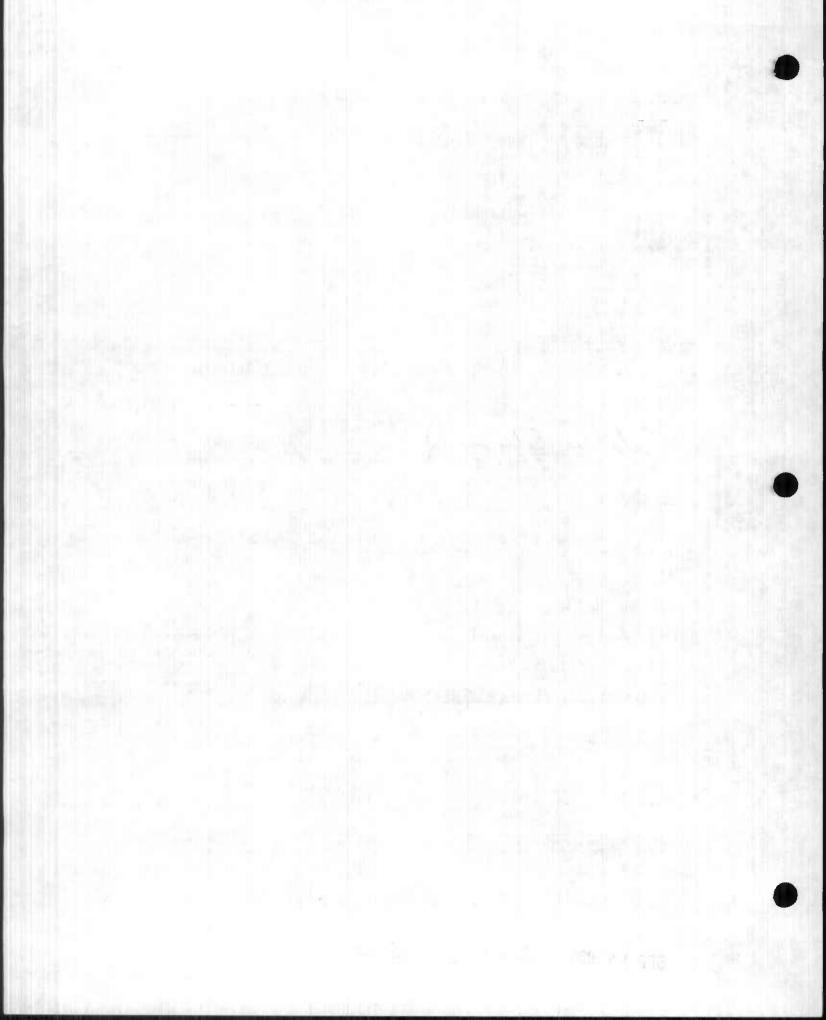
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30. Nema end addrass of person who complated causa of dash (Item 23e) (Type, Print)

32. Registra

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31. Data filed (Month, Day, Yaar) SEP 1 9 2000



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Date of Death **Physician** HARTZELL CONARD 13 11:58 A.M. 00 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 3A/LIMORE N/A Universi mac | S/4/F/17 | S. Dete of Birth | Hours | Min. | Month, Day, Year) 5. Sociel Security Number If Under 1 Yeer 6 Say 7. Age (In yrs. lest birthdey) Birthplece (Stete or Foreign Country) **Funeral** 1MM 2□ F Months Deys 56 1944 Director 219-42-1016 Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. CECIL ELKTON Yes 2 No Director hams 23s or 28a-f must be notifi 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 358 WEST MAIN ST. 21921 USA Funeral 12. Wes Decedent Ever in U.S.
Armed Forces?
X Yes 2 No
17/9s, Give
Yeer or Dates: 1965-68 Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Stetus Black, White, etc. 1 Never Married 2 Merried 8 21215-0020 1 ☐ Yes 2 🛛 No Specify: Specify: WHITE g 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) SIGN MECHANIC 12 Maryland 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) 89 8 Mental RAYMOND HARTZELL marked PEARL B. SMITH 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 358 WEST MAIN ST., ELKTON, MD. 21921 MARCUS HARTZELL/SON Health Item 27 i Saltimore, 20b. Plece of Disposition (Neme of 20c. Location - City or Town, State 20a. Method of Disposition Dete BALTIMORE WASHINGTON 컴 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 8 9/17/00 LAUREL, MD. CREMATORY
22. Name end Address of Fecility any in CHARLES S. ZEILER & SON, INC. 2521 6224 EASTERN AVE., BALTIMORE, MD. 21224 23a. Pert1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediete Ceuse (Finei disease or condition resulting in death) Examiner Due to (or es e consequence of) Examine ANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequenca of): Box 68760 Physician/Medical Due to (or es e consequenca of): P.O. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown À of Vital Records, 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OA 1 Yes 2 No Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division or Attending t Neturel 5 Pending investigation 1 Yes 2 No 2 Accident after death 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours of To the Funeral 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end piece, and due to the cause(s) and manner stated. 29e, Certifier å 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Street Baltimore

State Registrar 31. Dete filed (Month, Day, Year)

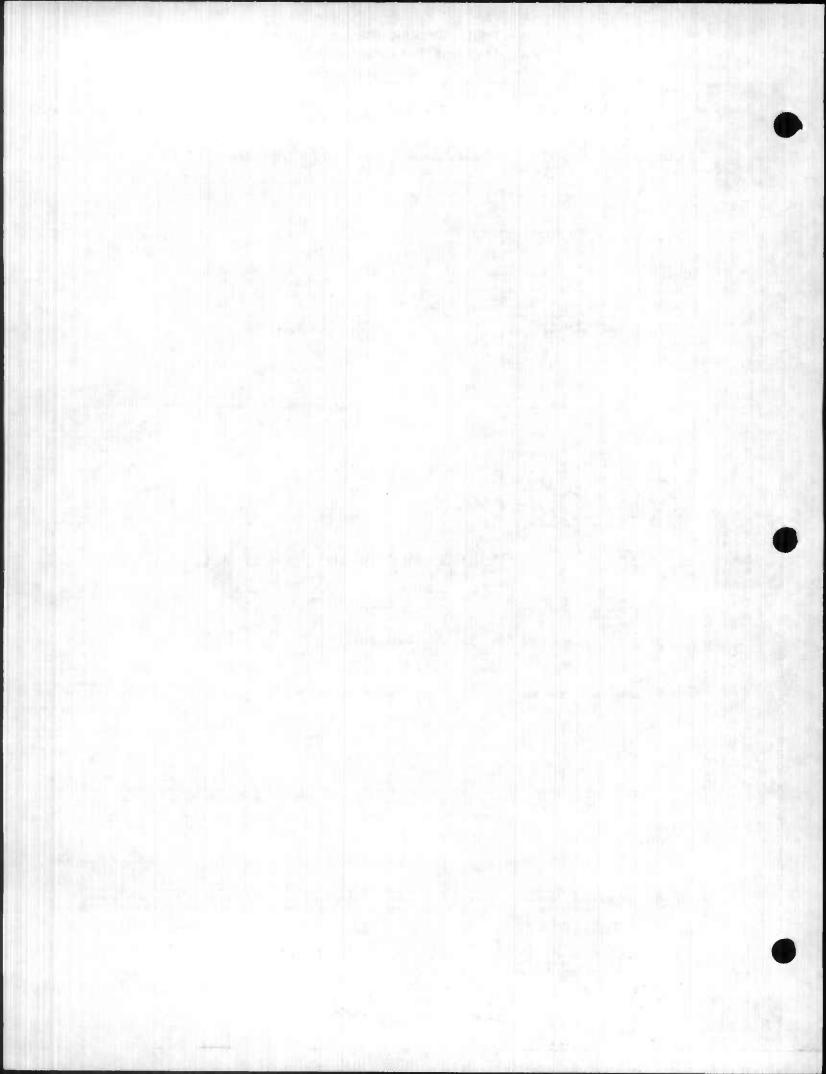
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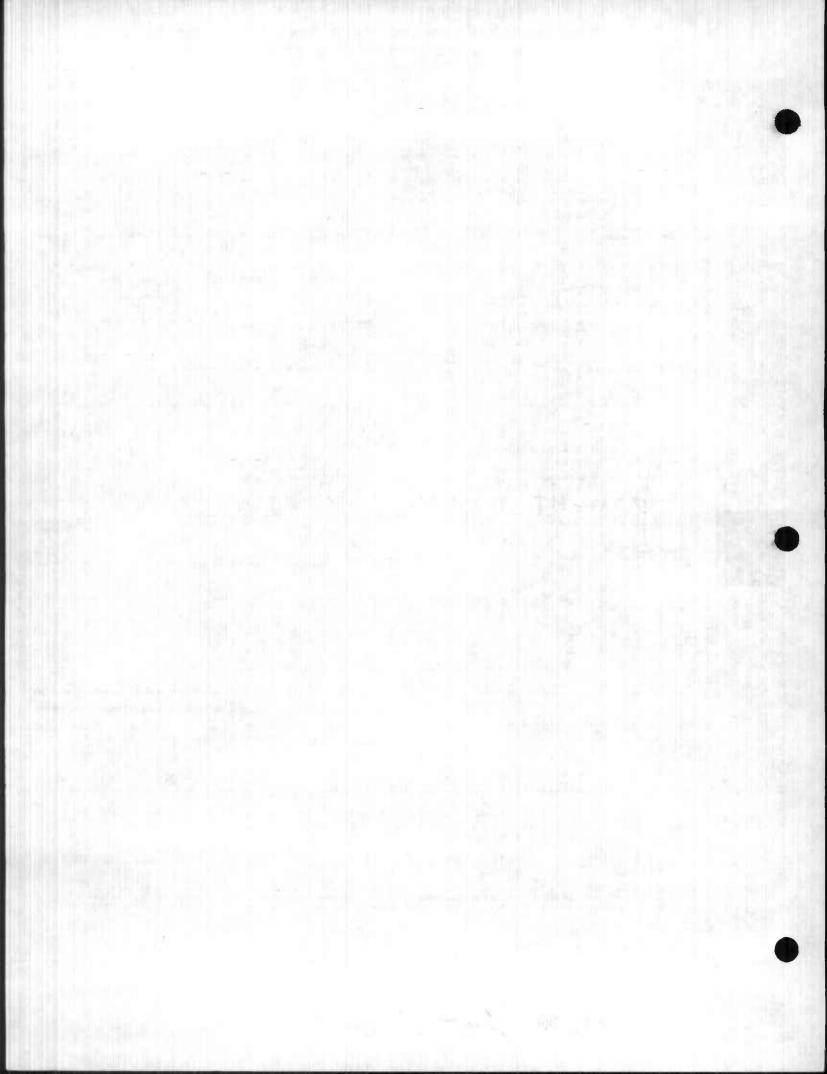
Registrer's Signeture

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		State of	Maryland		rtment of <i>tificate o</i>				giene Reg. No	U	0 2	9440
Physician /Medical	Decedent's Name (First, Middle, I	Judith	Law Pit	tt- Hu	nter			2. Date of De Month 9	15	200		4:45 a.m.
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Funeral Director	5501 Vantage 5. Social Security Number 6. 231-52-2193		Age (In yrs. Ia 61	st birthday) Yrs.	If Under 1 Ye Months Day	er If Unde		8. Dete of Birt (Month, Da 8-19-	y Year			e (State or Foreign
	Usuat Residence of Decedent  10a, State 10b, County		100 City	Town or Loc	ention						104	. Inside City Limits
be notified at Director	Md Howar	nd		umbia	ation							1 ☐ Yes 2 ☐ No
be notified	10e. Street and Number	d	001	umbra	10f. Zip Code	9			10g. Ci	tizen of Wi	hat Country	?
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by Funeral	11. Merital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	es? DXNo		/as Decedent of Yes, specify C			cify Yes or No Rican, etc.)		Black	- Americen , White, etc Black	
Completed	15. Decedent's (Specify only highest of	Educetion grade completed)		16a. Decede	ent'a Usual Oci	Occupation done duning most of working retired)			16b. Kind of Business/Industry			Ary
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	12th grade 17. Father's Name (First, Middle, La		vegree			me (First, Middle, Meiden Surneme)						
To Be	Maynard H. Law					Mal	ena E	Burwell	11			
	19a. Informent's Neme/Relationship (Type, Print)  Lori Flack - Daughter  19b. Mailing Address (Street end Number or Rural Route Number, City or Town, S 7726 Mayfair Circle Ellicott City, M											
	LOT1 Flack - Ua 20a. Method of Disposition	aughter	20b. Plece of Disposition (Neme of									
	1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Removal from State cemetery, cremetory or other plece)									
8000	21. Signature of Funeral Service Lic	f	MOSA	22.	Name and Add larch W	dress of Eacil	H				W.	215
etached for use as the bunal-transit and place the bunal-t	Immediate deuse (Final disease of Condition resulting in death)  Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	Due to (or a	as a consequas a consequ	uence of):	yel	on	<u> </u>				mo
hysici	Part II. Other significant conditions	contributing to deat	h but not result	ting In the un	derlying ceuse	ceuse given in Pert I. 23b. Di				Did tobacco use contribute to the cause of d		
								10	Yss :	2□ No	3 Probet	bly 4 ☐ Unknown
Completed by								24a. Wes	an auto	opsy	availe	autopsy findings able prior to pletion of ceuse eth?
Comp								10	Yes 2	XINO	1 🗆 Y	res 2000
8	25. Was case referred to medical examiner?	Hospital:				26. Plac	e of Deeth	(Check only o	one)			
P P	1 Yes 2 No  27. Manner of Death 1 Thaturel 5 Pending 2 Accident Investigat	28a. Dete of (Month,		R/Outpatient 28b. Time of Injury	28c. lr	njury at Nork?		ne 5 Resi				
Certification:	3 ☐ Suicide 6 ☐ Could not determine	289. PIECE OF	Injury - At hom, etc. (Specify)	ne, farm, stre	et, factory, offi	се	2	8f. Location ( City or To			er or Rurel R	Route Number,
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completely filled Medical Ce	29b. Signature and little of certifier.	0	20	Alle	29c. Lico	ense number	1 /	101	29d. Do	ete signed	(Month, De	y, Year)
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50	30. Name and address of person wh	south	(5 un	ld,	Poor	an	187	1	3/	AT	MO	945 57
State Registrar	31. Date filed (Month, Day, Year)	2000 32. Reg	istrer'a Signatu	A	los	1/1						

DHMH 16 Rsv 6/95



State of Maryland / Department of Health and Mental Hygiene [][]

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** Month Clara Link Haasis 17, Sept. 2000 11:30 PM /Medicai 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5102 Avoca Ave. Ellicott City Howard 8. Dete of Birth (Month, Day, Year) Oct. 20, 1 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1□M 20F 213-20-5391 75 Yrs. Director 1924 Maryland Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 238 5102 Avoca Ave. 21043 United States death "natural", or items 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Biack, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 ie marked other than "natural", or her any Injury or other traumatic event, tre Medical Exacutes Date. 1 Never Married 2 Married altimore, Maryland 21215-0020 If Yes, Give Year or Dates: 1 Yes 2 No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Manager Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Link Lula Hartmann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene R. Haasis / spouse 5102 Avoca Ave. Ellicott City, MD. 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Sept. 18 Metro Crematory Catonsville, MD. 2000 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility s Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043 401091 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final Brain Metastanis disease or condition resulting in death) **Examiner** Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760, Physician/Medical Due to (or es a consequence of) Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of deeth? 1 Yas 2 No 3 Probably 4 Unknown Records, by 24b. Were sutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2000 1 Yes 2 No of Vital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred After Division 5 Pending Investigation 1 Natural death. 1 Yes 2 No 2 Accident s efter death 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours e Medicai 29a. Certifier Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) 29c. License number (Type, Print)
St Agnes Concer Certer Got Carron fore Md 21229 30. Name and address of person who complete eted cause of death (Item 23a) (Type, Print) WATERFIELD MO 32. Tegistrar's Signature 31. Date filed (Month, Day, Year) SEP 1 9 2000 State

**DHMH 16 Bay 6/95** 

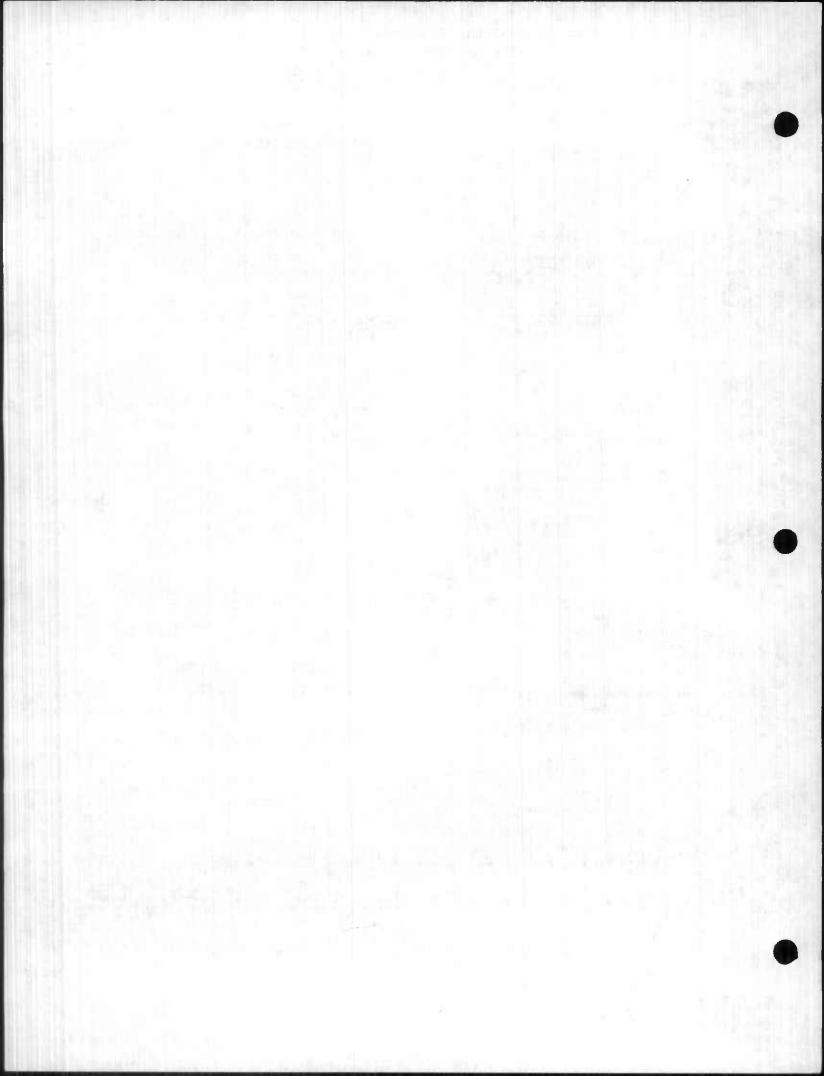
Registrar

State of Maryland / Department of Health and Mental Hygiene 00 291,42

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Maryland 21215-0020	Send and and and and and and and and and a	-	19e. Informant's Name/Reletionship (			19b. Meit	ting Address	(Street	end Number	er or Run	al Route Numb	er, City or Town,	Stete, Zip	Code)
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Division	5 # 5 S	Certification:	4 Homicide	building	, etc. (Specil	y) .					City or To	wn, Stete)		
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	ithin ;	Xe.	29b. Signartire end title of certifier	A P	Hen	-01	296	c. Licen	se number			29d. Dete signe	d (Month.	Day, Year)
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			1000	~,		10	, ,	5	0,1			377	0 1	2000
	10	1	30. Name and address of person who	completed cause	of deeth (tter	n 23a) (Type	Print)	· .	CL R	3	CATO	nsvill	6,	MD 21228
	10		P. JUNGTON	,190,	100		1606		1	,	- //			9
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DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 2. Dete of Death 3 Time of Death 1. Decadent's Name (First, Middle, Last) **Physician** 31 ELIZABETH LOUISE JONES AUG. 2000 1345 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner The Memorial Hospital Easton Talbot If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** 10 M 20 F Days Months Yrs. 242-36-6444 SEPT. 18, 1928 NORTH CAROLINA Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD QUEEN ANNE STEVENSVILLE 1 Yes 2 No Director Examiner must be notifi 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8 "natural", or items 23s 118 CONGRESSIONAL DRIVE 21666 USA Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Yeer or Dates: KOREAN Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status fled within 72 hours after 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 X No Specify Specify à 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cottege (1-4or 5+) REGISTERED NURSE HEALTH CARE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 98 is marked THERON LEDBETTER SALLY LYNCH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Pages 1 and 2 s ment of Health an ant: If Hem 27 is 1 118 CONGRESSIONAL DRIVE, STEVENSVILLE, MD 21666 FORREST JONES/ HUSBAND 20b. Ptace of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriai 2 X Cremation 3 ☐ Removal from Stete CHESAPEAKE CREMATION CTR 9-2-00 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Servica Licen 22. Neme and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, 10 21619 deeth. Do of enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the deeth. shock, or heart feiture. List only one ceuse on each line. Interval Between Onset and Death Physician immediate Cause (Finel disease or condition resulting In deeth) /Medical A~DXID Examiner Due to (or as a consequenca of) Examine ruwning attending physician and for use as the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): 23b. Did tobacco usa contribute to the cause of death? Part fl. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Vea 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No epital or Attahding Physician: Theorems after death.

neral Director: After this certificate filled in by the funeral director, pe Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpetient 2 ER/Outpatient 3 DOA 2 28d. Describe how injury occurred DROWNED IN 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28c. injury at Work? Certification: 5 Pending investigation 1 Naturai 1 ☐ Yes 2 ☒ No 2 Accident AUG 26, 00 SWIMMING POOL 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number City or Town, Stete) 118 Congressional Dr. 28e. Plece of Injury - At home, farm, street, factory, offica building, etc, (Specify) 4 Homicide Stevensville Md. HOME within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29a. Certifier PhoiciAN 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifief

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**DHMH 16 Ray 6/95** 

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vital Records,

State Registrar JAMES P. ELMORE, M.D., 219 S. WASHINGTON ST., EASTON, MD 21601
31. Date flied (Month, Day, Year)

32. Registrar's Signeture

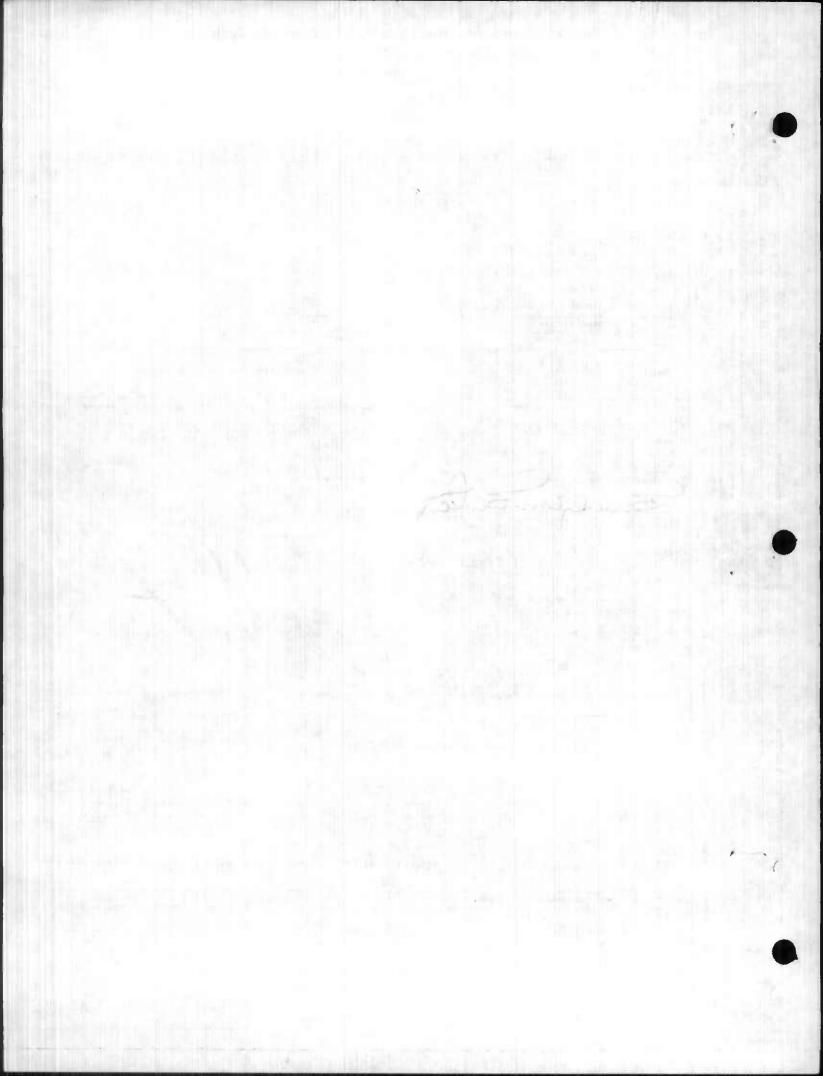
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signeture

Sparks

50328

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Herman Alse Johnson, Jr. September 16, 2000 4:21 A.M. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 223 Charmuth Road Lutherville Baltimore Co. Hours Min. April 20,1919 5. Social Security Number 6. Sex 1 → M 2 → F If Under 1 Yeer 9. Birthplace (State or Foreign Country)
Portsmouth, Virginia 7. Age (in yrs. last birthday) Days 81 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Baltimore Co. Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? United States of America 223 Charmuth Road 21093 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes, Give Yeer or Detes: W.W.II 14. Race - American Indian, Biack, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Merried 1 Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Administrative Coordinator n/a Whiting-Turner 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Herman Alse Johnson, Sr. Estelle Parks 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Helen Ceclia (nee Sawicki) Johnson 223 Charmuth Road Lutherville, Maryland 21093 20b. Piace of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 9/19/2000 Baltimore, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 or plicetions that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, at only one cause on each line. 23a. Part1. Enter the disease shock, or heart faiture. Approximate intervat Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) OCALDIA Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of)

**Physician** /Medical Examiner

and

the attending physician

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To the Hospital within 24 hours a To the Funeral L

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page 2 should

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Medical Certification: To Be Completed

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The law requires that the death certificate be executed

Box 68760.

P.0.

Division of Vital Records.

or Attanding Physician:

**Physician** 

/Medical

Examiner

212-18-0181

10a. State

Maryland

11. Maritai Stetus

**Funeral** 

Director

23s or 28s-f show

Herns

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Hygiene.

other

permit. Pages 1 and 2 ahould be filt Department of Haalth and Mental Hy Important: if fism 27 is marked oth any injury or other traumatic avam Rada.

Director

Funeral

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Completed

traumatic avant, the Madical Examiner must be notified at

with the Maryland

filed within 72 hours after death

Saitimore, Maryland 21215-0020

Physician/Medical Examiner Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting to deeth) Last

Part II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Wes an autopsy parlormed? 24b. Were autopsy findings available prior to completion of cause of death? 2 1 No 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical 1 Yes 2 No 27. Menner of Death

6 Could not be

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of injury (Month, Dey Year) 5 Pending investigation

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred

1 Yes

26. Place of Death (Check only one)

28c. Injury at Work? 1 Yes 2 No 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end manner stated.

29b. Signeture and title of certifier

29c. License number 37362 29d. Date signed (Month, Dey, Year)

30. Neme and address of person who completed cause of death (ttem 23a) (Type, Print)

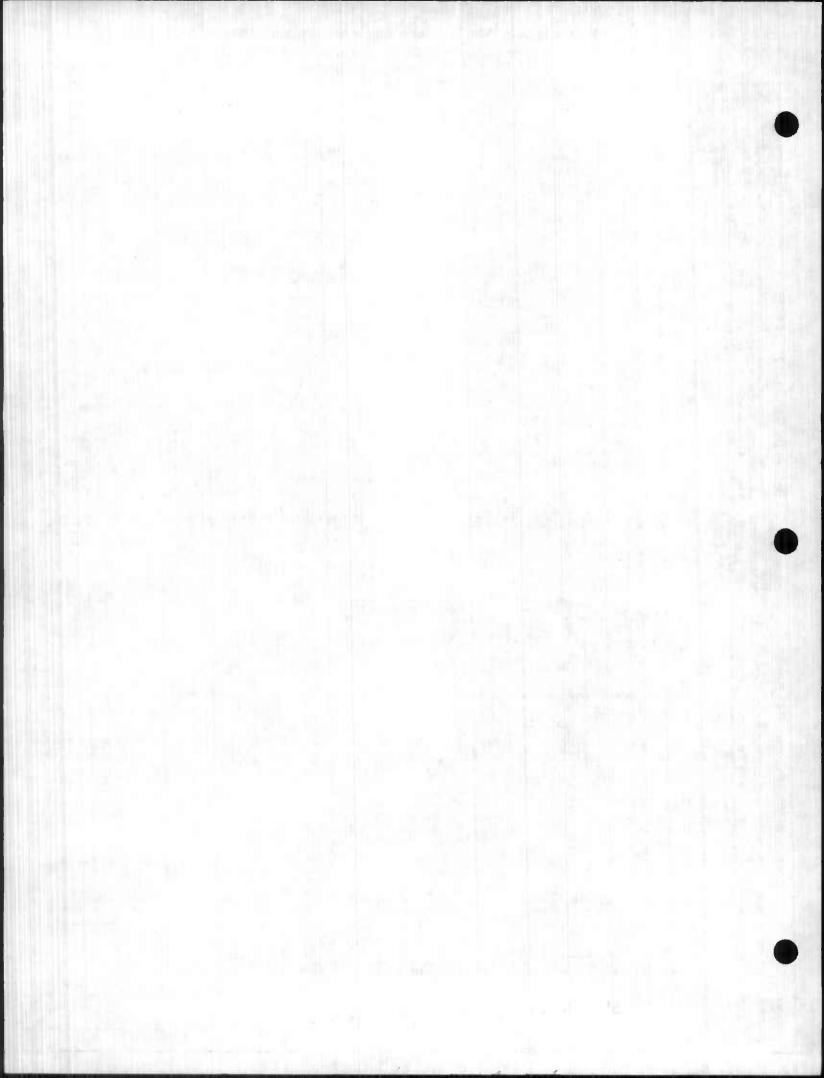
SerATTIS

Currence Moriog3

State Registrar

31. Date filed (Monts Pap Your) 9

32. Registrar's Signature

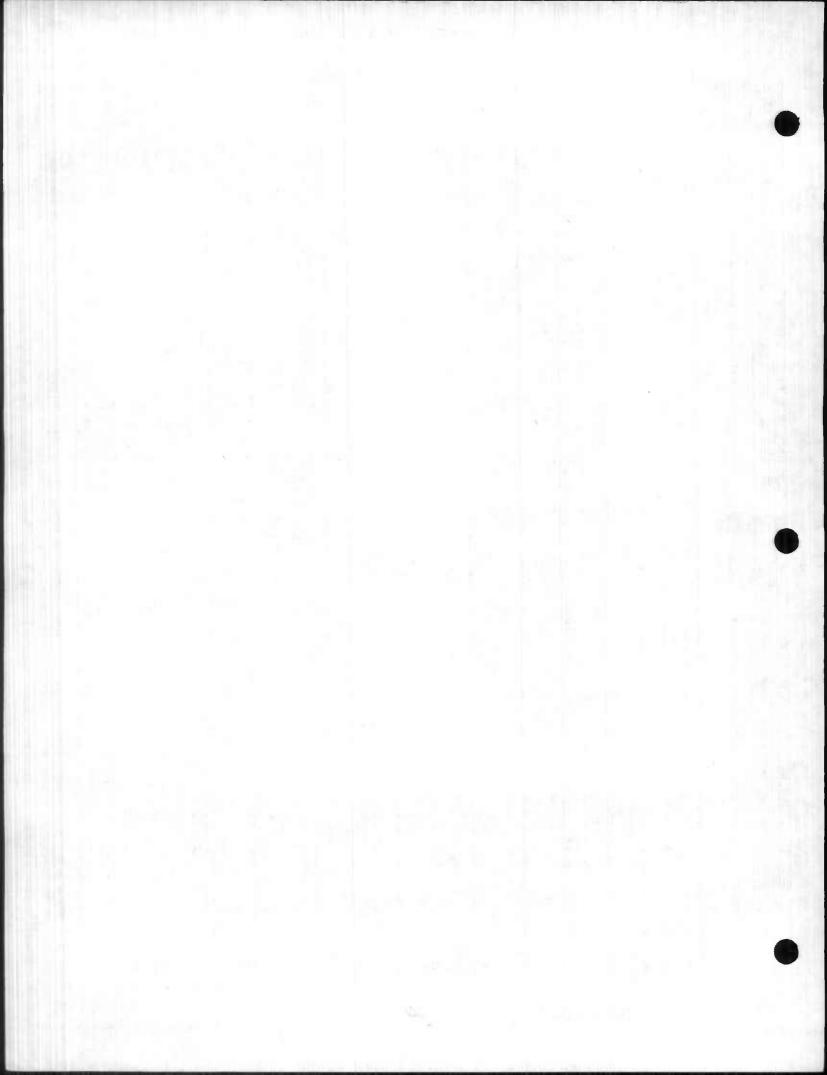


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	0	0	- Inve	-	- 0	- 8	,

DHMH 16 Rev 6/95

	IE JENSEN  1. Decedent's Name (First, Middle, Las	ot)	Cert	ficate of	Death	2. Date of De			3. Time of Death
Physician /Medical	Carla Sorine J	uhl Jensen				SEPT.	17, 200	eer	1722 PM
Examiner	4a Facility Name (# not Institution, give HOWARD COUNTY HO				4b. City, Town, or COLUMB		4c. County of		
Funeral Director	N/A	M AFIF	( last birthday) Yrs.	If Under 1 Year Months Deys	If Undar 24 Hrs. Hours Min.		th sy, Year)	). Birthpled Country	ce (State or Foreig ) nmark
fland M G M	Usual Residence of Decedent  10a. Stete 10b. County	10c. C	ity, Town or Loca	tion				10d	. Inside City Limits
o Man	Denmark N/A		Esbje:	cg					1 ☐ Yas 2X No
or 28s-f a be notified Director	10a, Streef and Number			10f. Zip Code			10g. Citizen of Wh	et Country	?
aral ara	Graadybet 27st.		10 40 14	670				mark	Indian
at, or harms 22a or 28a-f sho Examiner must be notified at by Funeral Director	11. Meritel Stetus  1 ☐ Never Merried 2 ☑ Merried  3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever in & Armed Forces?  1  Yes 2 No If Yes, Give Yaer or Detas:		es Decedent of F es, specify Cuba	dispenic Origin? (S an, Mexican, Puerl Specify:	to Rican, etc.)	Bleck, Specify:	White, etc	
ical in	15. Decedent's Ed (Specify only highest gra	lucation	16a. Decede	nt's Usuel Occup	pation	rkina	16b. Kind of Busi	ness/Indus	stry
ygiene. her than hattun it, the Medical Completed	Elementery/Secondary (0-12)	College (1-4or 5+)			during most of word)	nang	B C	h = = =	
Co Co	17. Father's Neme (First, Middle, Last)		Sto	ore Mana		me /First Middle	ECCO S		
ental H sad oth c even o Be	Carl Juhl				Tinn				
A many	19a. Informent's Neme/Reletionship (	Type, Print)	19b. Melling	Address (Street			er, City or Town, Si	ete, Zip C	ode)
277	Mrs. Heidi Johanse	en/Grand Daugh	ter 10	710 Hard	ling Rd.	Laurel	, Marylan	d 20%	723
ret: If Nam rry or othe	20a. Method of Disposition		Plece of Disposit	ion (Neme of tory or other ple	ce)	Dete	20c. Location - C	ity or Towr	n, Steta
ury or	1 ☑ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Treenigh	nedskirk	ten	9/23/00	Esbjerg	, Der	nmark
Depart Import any in	21. Signature of Funerel Service Licen	1 Durch	111/1	Neme and Addre	R		son Funer Maryland		
nysician Medical xaminer	23a. Part1. Enter the disease, or complete shock, or heert failure. List or ly limmediete Cause (Finel disease or condition resulting in deeth)	. Mu	(or es a conseque	ple	I	inju	urie	5	itervel Between
ing physician and e as the burial-transit Medical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	c	or as a conseque						
attending for use as clan/Me		d							
0 % 7	Pert If. Other significant conditions of	ontributing to death but not ra	sulting in the und	arlying cause gi	ven in Pert I.		tobacco use centr Yes 2 No 3		he cause of deat bly 4 Unkno
should should						24a. Wes	en autopsy ormed?	avails	autopey findings able prior to detion of cause ath
ate has page 2						10	Yes 2□No	1 625	res 2□No
is certificate director, pag To Be Co	25. Wes case referred to medical exeminer?	FEET STATE			26. Place of De	ath (Check only	one)		
T die	1 XYes 2 No 27. Menner of Deeth	28a. Dete of Injury	28b. Time of	3 DOA Ott	4 LI Nursing F	-	idence 6 Other		4
octor: After by the funa- ification	1 Netural 5 Pending 2 Accident Investigation	9/17/00	1510	M 1	rk? Yes 2 ☑ No	Passe	truck	70	biects
	3 Suicide 6 Could not be determined		nome, ferm, stree	t, factory, office		201 Location	(Street end Number wn, Stete)	or Bural A	
within 24 hours after To the Funeral Dir completaty filled in Medical Cert		ysician: To the best of my kn hiner: On the basis of examin end mannar stated.							
To the compl	29b. Signature and title of certifier			29c. Licens	se number		29d. Dete signed	(Month, Da	ıy, Year)
Y/	1 Kut	aner, N	T.D.	0.	C.M.E		SEPT.	18,	2000
no	30. Name and address of person who o	completed couse of deeth (Ite	m 23a) (Type, Pr 11 Penn	Street,	Baltimo	re, Mar	yland 212	01	
State	31. Dete filed (Month, Day, Year) SEP 1 9 20	32. Registrer's Sign		Spare					

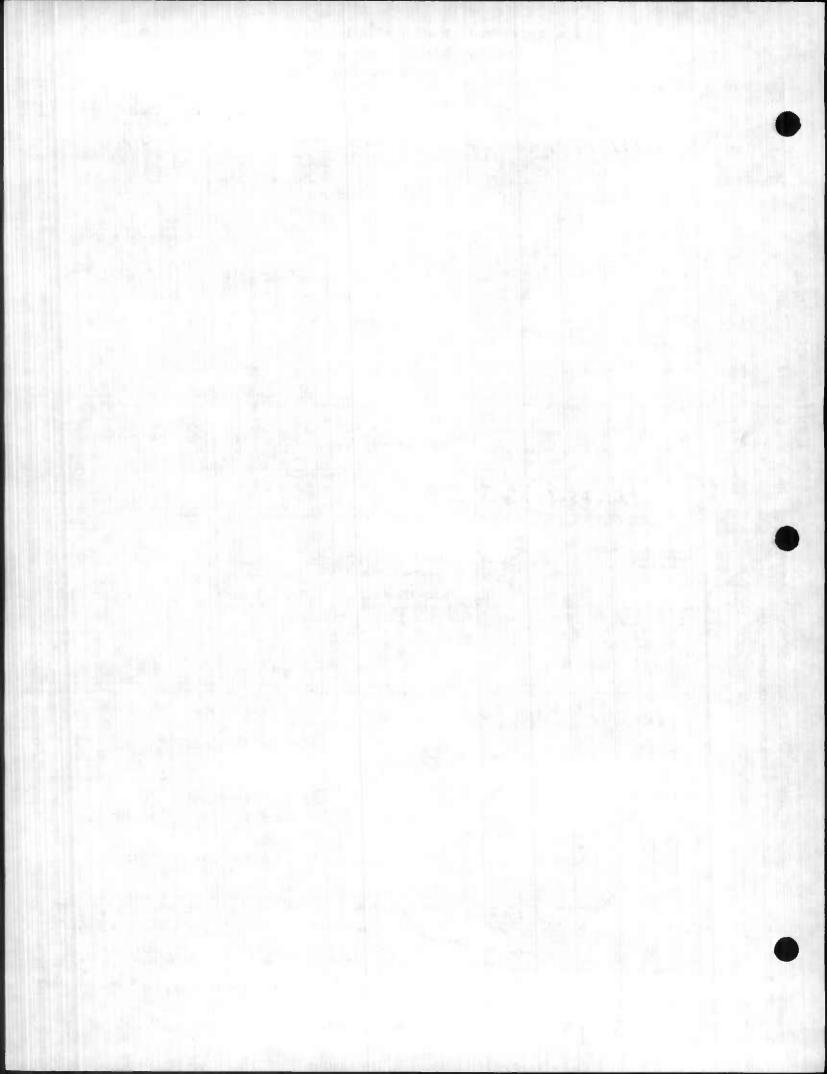


State of Maryland / Department of Health and Mental Hygiene 00 29446

nysician				Certificate of	or Death	Re	g. No.		
ivsician	1. Decedent's Name (First, Mid		11111			2. Dete of Death Month	Dev	Voer C	Tima of Death
Medical	HOWARD	E.	JONES,	SR.		09 1	5 20	000 8	103 A.M.
iner	4a Facility Name (If not Institute	ion, give street and numi	ber)	, .	4b. City, Town, or Loc		4c. County	of Death	
4	DINGI H	ospital	0+B	altimore	ear If Under 24 Hrs.	nore	~	A	101 h F '
	5. Social Security Number 212–30–8057	6. Sex 7 1 ☑ M 2 □ F	. Age (In yrs. last i	Yrs. Months Da	lys Hours Min.	8. Dete of Birth Month, Dey 04-10-1	932	9. Birthplace Country	(State or Foreign
+	Usuat Residence of Decedent  10a. State 10b. Coun	tv	10c, City, To	wn or Location				10d. I	nside City Limits
Director	MD N/A			BALTIMORE					¥Yes 2□No
ŀ	10e. Street and Number			10f. Zip Coo	ie	10	g. Citizen of V	Vhat Country?	A
	3800 BELVEDERE	E AVENUE			21215		U	SA	
ŀ	11. Merital Stetus	12. Was Deced	ent Ever in U,S.	13. Wes Decedent	of Hispanic Origin? (Spe Cuben, Mexican, Puerto F	cify Yes or No-		e - American fo	ndian,
	1 Never Merried 2 ☐ Mr	arried 1 7 Yes 2	No	1 ☐ Yes 2 🛣		noan, etc.,	Specify	k, White, etc.	
	3 Widowed 4 Divorce	ed Yeer or Dat	es: 51-54					BI	ACK
		ent's Education nest grade completed)	16	a. Decedent's Usuel Oc (Give kind of work do	ccupation one during most of workin tired)	1	6b. Kind of Bu	ısiness/industi	У
	Elementery/Secondery (0-12	) College (1-4			(tired)				
	17. Father's Neme (First, Middle	e, Last)		ABDRIVER	18. Mother's Name	(First, Middle, M		SPORTAT	CION
ı	ALBERT KING				САТИЕРТЬ	NE JONES			
-	19a. Informant's Name/Relation	nahip (Type, Print)	1:	9b. Meiling Address (Str	reet end Number or Rura		City or Town,	Stata, Zip Coo	fa)
	HOWARD E. JONE	ES, JR. /SON	1	3016 VIRG:	INIA AVENUE	BALTO.	, MD.	21215	
	20a. Method of Disposition		ceme	of Disposition (Name of tery, crametory or other	f place)	Date 2	0c. Location -	City or Town,	State
1	128 Buriet 2 Cremetion			SON VETERAL	N CEM 9/3	20/2000	OWINGS	MILLS.	MD
1	21. Signature of Funeral Service	ne Licensee	0	22. Name end Ad	dress of Facility				
1	1 James	oa. No	Low		. MORTON & S			. 21217	7
	23e. Pary Enter the disease, show or heart failure. Li	or complications that can	used the death. D	o not enter the mode of	dying, such es cerdiac o	r respiratory arre	st,	Ap	proximate prvel Between
		7		/1				On	set and Death
1	Immediate Cause (Final disease or condition resulting in deeth)	, Kes	pirato	cy /a. /4	re			/	day
	Toodking in deducty	,-	Due to (or as	a consequence of):				9	1
		b	1	ema_				12	oyr .
	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying		Due to (or as	a consequence of):					
	that initiated events	c	Due to (or as	a consequence of):					
	resulting in death) Last								
		d							
	Part If. Other significant condi		th but not resulting	in the underlying ceuse	e given in Pert I.	23b. Dld tot	Dacco uae co	ntribute to the	cause of death
r II yaiciai viii	Part II. Other significant condi			in the underlying ceuse	e given in Pert I.	23b. Did tot			cause of death
	Part II. Other significant condi	tions contributing to dea		in the underlying ceuse	e given in Pert I.	12 vs	s 2□No	3 Probabl	y 4 Unknow
	Part II. Other algnificant condi	tions contributing to dea		in the underlying ceuse	e given in Pert I.	1)Xve	s 2□No	3 Probabl	y 4 Unknow autopsy findings ble prior to stion of cause
	Part II. Other atgniffcant condi	tions contributing to dea		in the underlying ceuse	e given in Pert I.	12 vs	s 2□ No autopsy led?	3 Probabl	autopsy findings ole prior to stion of cause th?
1	Per phra	tions contributing to deal		in the underlying ceuse		24e. Was ar perform	s 2 No autopsy ed?	3 Probable  24b. Were availat comple of deal	autopsy findings ale prior to stion of cause h?
	Per phin	tions contributing to deal	v Di	in the underlying cause Seas. L  Dutpatient 300 DOA	26. Place of Deeth	24e. Was an perform	s 2 No autopsy s 2 No	3 Probabl  24b. Were availat comple of deat	autopsy findings ale prior to stion of cause h?
	25. Was cese referred to medic examiner? 1 Yes 2 No 27. Manner of Death	tions contributing to deal	patient 2 ER/	Scas. 2  Dutpatient 3 DOA  Time of 28c.	26. Place of Deeth Other: 4 □ Nursing Hon	24e. Was an perform	autopsy sed?	3 Probable  24b. Were availated complement of deal of the second of the	autopsy findings ale prior to stion of cause h?
	25. Was case referred to medic examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pencinves	tions contributing to deal Vascula Hospitel: 1 In In Ingerigation	patient 2 ER/	Scas. 2  Outpatient 3M DOA  Time of Injury  28c.	26. Place of Deeth Other: 4 \( \text{ Nursing Hon} \) Injury at \( \text{ Vork?} \) 1 \( \text{ Yes} \) 2 \( \text{ No} \)	24e. Was ar perform  1  Ye  (Check only one	autopsy led?  s 2 No s 2 No s 2 No s 2 Oth moe 6 Oth w injury occur	3 Probabl  24b. Were availat comple of deal 1 Ye er (Specify)	y 4 Unknow autopsy findings ale prior to ation of cause h? as 2 No
	25. Was cese referred to medic examiner? 1   Yes 2   No  27. Manner of Death 1   Natural 5   Pencident 3   Suicide 6   Coul	tions contributing to deal  Vascula  tal Hospitel: 1 In In In In In In In In In In In In In	patient 2 ER/injury Dey Year)	Scas. 2  Outpatient 30 DOA  Time of Injury  28c.	26. Place of Deeth Other: 4 \( \text{ Nursing Hon} \) Injury at \( \text{ Vork?} \) 1 \( \text{ Yes} \) 2 \( \text{ No} \)	24e. Was an perform	s 2 No sautopsy sed? s 2 No s) nce 6 Oth w injury occur	3 Probabl  24b. Were availat comple of deal 1 Ye er (Specify)	y 4 Unknow autopsy findings ale prior to ation of cause h? as 2 No
	25. Was cese referred to medic examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pencinve: 2 Accided 6 Could Homicide	tions contributing to deal  Vascula  Hospitel: 1 In In In In In In In In In In In In In	patient 2 ER/ tnjury Dey Year) 28t f tnjury - At home, ,, etc. (Specify)	Outpatient 3M DOA  Time of Injury M  farm, street, factory, off	26. Place of Deeth Other: 4 \sum Nursing Hon Injury at Work? 1 \sum Yes 2 \sum No	24e. Was ar perform  1   Ye (Check only one) ne 5   Resider 28d. Describe hor City or Town,	s 2 No sautopsy sod? s 2 No s) nce 6 Oth w injury occur eet end Numb State)	3 Probable  24b. Were available completed of deal available completed available complete for the complete fo	y 4 Unknow autopsy findings ble prior to stion of cause h?  bs 2 No  oute Number,
	25. Was cese referred to medic examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pencilone  2 Accident 3 Suicide 6 Could  4 Homicide 6 Couldete	tions contributing to deal  Vascula  Hospitel: 1 In In  ding stigation d not be rmined  28e. Place of building  ring Physician: To the bast Examiner: On the bast Examiner:	patient 2 ER/ Injury 28t  Injury - At home, , etc. (Specify)  est of my knowled is of my knowled is of my knowled.	Dutpatient 3M DOA  Time of Injury M  farm, street, factory, off	26. Place of Deeth Other: 4 \( \text{ Nursing Hon} \) Injury at \( \text{ Vork?} \) 1 \( \text{ Yes} \) 2 \( \text{ No} \)	24e. Was an perform  1  Ye  (Check only one to the cell of the cel	autopsy led?  s 2 No s) noce 6 Oth w injury occur. State) use(s) and ma	3 Probabl  24b. Were availat comple of deat 1 Ye er (Specify) red	y 4 Unknow autopsy findings le prior to stion of cause h? ss 2 No
	25. Was cese referred to medic examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendiciper 2 Accident 3 Suicide 6 Coul dete	tions contributing to deal    Vascula   Hospitel:   I Interpretation	patient 2 ER/ Injury 28t Injury - At home, , etc. (Specify)  est of my knowled is of my knowled is of my knowled.	Outpatient 3M DOA Time of Injury M farm, street, factory, off	26. Place of Deeth Other: 4 Nursing Hon Injury at Work? 1 Yes 2 No ice 2	24e. Was an perform  1  Ye  (Check only one me 5  Resided Resi	autopsy led?  s 2 No s) nnce 6 Oth w injury occur eet end Numb State) use(s) and mate and place,	3 Probabl  24b. Were availat comple of deat 1 Ye er (Specify) red	y 4 Unknow autopsy findings ale prior to ation of cause h? as 2 No autopsy findings ation of cause h? as a unit of cause d. a cause(s)
	25. Was cese referred to medic examiner?  1   Yes   2   No  27. Manner of Death  1   Natural   5   Penc invest  3   Suicide   6   Coul dete  29a. Certifier (Check only one)	tions contributing to deal    Vascula   Hospitel:   I Interpretation	patient 2 ER/ Injury 28t Injury - At home, , etc. (Specify)  est of my knowled is of my knowled is of my knowled.	Outpatient 3M DOA Time of Injury M farm, street, factory, off	26. Place of Deeth Other: 4 Nursing Hon Injury at Work? 1 Yes 2 No lice 2	24e. Was an perform  1  Ye  (Check only one me 5  Resided Resi	autopsy led?  s 2 No s) nnce 6 Oth w injury occur eet end Numb State) use(s) and mate and place,	3 Probable  24b. Were availated availated availated availated availated availated and the second availated	y 4 Unknow autopsy findings ale prior to ation of cause h? as 2 No autopsy findings ation of cause h? as a unit of cause d. a cause(s)
	25. Was cese referred to medic examiner?  1   Yes   2   No  27. Manner of Death 1   Natural   5   Pend Invest 3   Suicide   6   Coul   dete  29a. Certifier (Check only one)  29b. Signeture and title of certifier	tions contributing to deal  Vascula  Hospitel: 1 In In  ding stigation of Month at Examiner: On the base and manner  tier	patient 2 ER/I Injury Dey Year)  If Injury - At home, Injury - At	Outpatient 3 DOA Time of Injury M farm, street, factory, off ge, death occurred at the and/or investigation, in recognitions of the street of	26. Place of Deeth Other: 4 Nursing Hon Injury at Work? 1 Yes 2 No lice 2	24e. Was an perform  1  Ye  (Check only one me 5  Resided Resi	autopsy led?  s 2 No s) nnce 6 Oth w injury occur eet end Numb State) use(s) and mate and place,	3 Probable  24b. Were availated completed availated completed and the series of the se	y 4 Unknow autopsy findings ale prior to ation of cause h? as 2 No autopsy findings blood of cause h? ation of cause blood of cause autopsy findings autopsy a
Medical Certification: To Be Completed by Physician/Medical	25. Was cese referred to medic examiner?  1   Yes   2   No  27. Manner of Death  1   Natural   5   Penc invest  3   Suicide   6   Coul dete  29a. Certifier (Check only one)	tions contributing to deal  Vascula  Hospitel: 1 In In  ding stigation of Month at Examiner: On the base and manner  tier	patient 2 ER/I Injury Dey Year)  If Injury - At home, Injury - At	Outpatient 3 DOA Time of Injury M farm, street, factory, off ge, death occurred at the and/or investigation, in recognitions of the street of	26. Place of Deeth Other: 4 Nursing Hon Injury at Work? 1 Yes 2 No lice 2	24e. Was an perform  1  Ye  (Check only one me 5  Resided Resi	autopsy led?  s 2 No s) nce 6 Oth w injury occur eet end Numb State)  use(s) and ma te and place, id. Dete signe	3 Probable  24b. Were availated completed availated completed and the series of the se	y 4 Unknow autopsy findings ale prior to ation of cause h? as 2 No autopsy findings ation of cause h? as a unit of cause d. a cause(s)

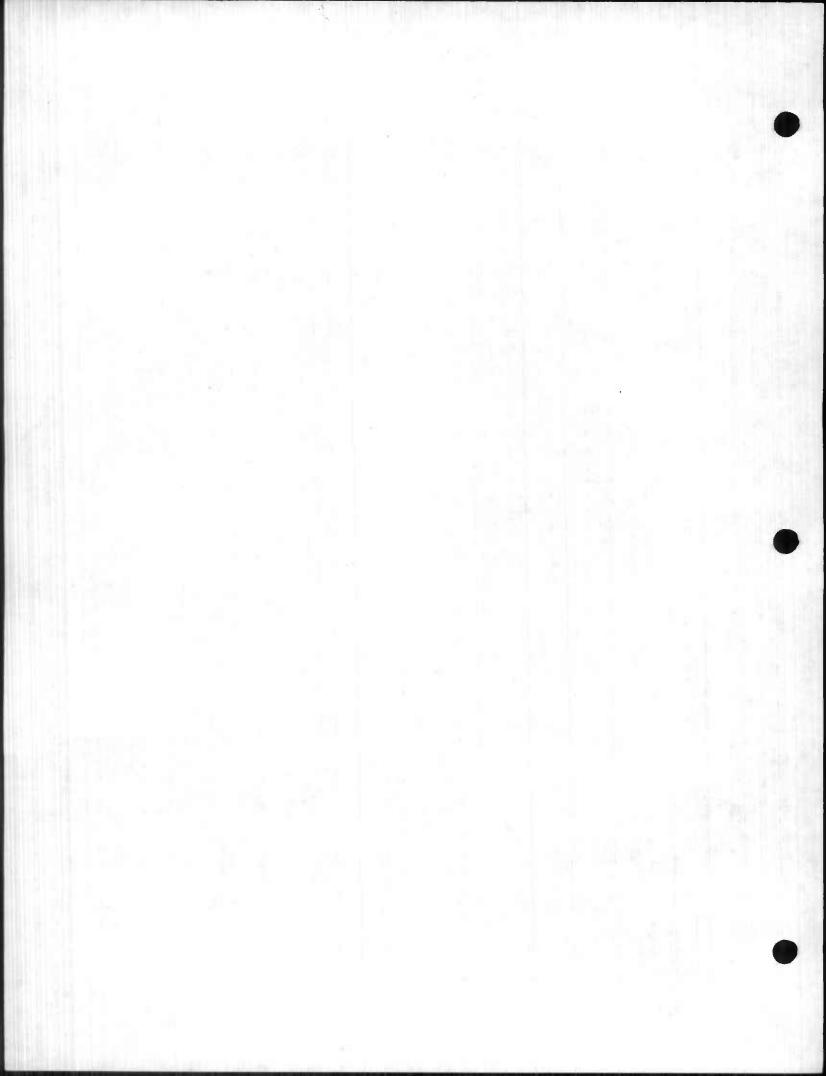
DHMH 16 Rsv 6/95

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene 0 29447

Director	i. Social Security Number 6. Se	street and number of the street and number of	MQSO Re (A) yrs. last birthday) 68 Yrs.	Re H Unda Months	er 1 Year	BA1	2. Date of Domonth or Location of Dear  I'm CRE  Hrs. 8. Dele of Bi (Month, D	Day Ye 15 8 th 4c. County of C	3. Time of Death  6:53 P  Death  Birthplace (State or Foreign Country)
Director	i. Social Security Number 6. Sec. 212-30-3024 Usuel Residence of Decedent 10b. County	OR FUTUR DX 7. Age (In			er 1 Year	BA1	timore	City	Birthplace (Stata or Foreign
Director	212-30-3024 10 Usuel Residence of Decedent 10a. Stete 10b. County	XX 2□ F					Hrs. 8. Dele of Bi (Month, D	irth (9.	Birthplace (State or Foreign
Director	10a. Stete 10b. County			1			OCT 10		RYLAND
Director		100	c. City, Town or Lo	ncation					10d. Inside City Limits
i Directo	ADDAL DYLAND	E. 1974							1 Yas 2 Ny
JO I		ORE	OWING	1			15	40-02	****
90	8 WINNER CIRCLE	APT 3C		101. 2	ip Code 2111	.7		10g. Citizen of What	
Funeral	11. Marital Status	12. Wes Decedent Ever Armed Forces?	in U,S. 13.	Was Dec	edent of h	lispanic Origin's	(Specify Yes or Nuerto Rican, etc.)	o- 14. Race - / Black V	Amarican Indian, Vhite, etc.
by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 □ No		1□ Yes		Specify:		Specify: E	
Completed	15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Us	ual Occup	ation during most of	wadring	16b. Kind of Busine	ess/Industry
pie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	use retire	d)	WOIKING		
5	12th		MAIN	TENA	NCE			GOODNOW	APTS
Be	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middle	e, Maiden Sumeme)	
10	EDWARD HALL					GENI	ESTER BRO	WN	
	19a. Informant's Neme/Relationship (T	ype, Print)	19b. Maili	ing Addre	ss (Street	end Number o	r Rurel Route Numi	ber, City or Town, Ste	te, Zip Code)
	Lillian Mitchell/	Cousin	8 W	inne	r Cir	cle Apt	t 3C, Owi	ngs Mills,	Md 21117
- 1	20e. Method of Disposition	20	Ob. Plece of Dispo	osition (N	eme of		Dete	20c. Location - City	
	1 巻 urial 2 Cremation 3 日 4 Donetion 5 Other (Specify,		GARRISO	N FOI	REST		9-20-00	OWINGS N	MILLS, MD
	21. Signature of Funda Secretaria	Suson au		WILL	IAM C			Y FUNERAL	HOME PA
	23a. Pert1. Exter the disease, or comp	lications thet caused the				ORTH AV		arrest,	Approximate Interval Between
	shock, or heart failure. List only o	one ceuse on each line.							Onset and Death
	Immediate Cause (Final	c MACINIA	1 . A M . A M		00/	2111/	211		1 1-000 1711
	disease or condition resulting in death)	. CARCIMO				MAN	<u> </u>		1 month
6		Due	to (or es e conse	quence of	):				
Examiner		b							
Xai	Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Disease or Injury	Due	to (or as e conse	quence of	):				
8	Cause (Disease or Injury	c							
edical	thet initieted events rasulting in death) Last	Due	to (or es e consec	quence of	):				
2		d.							
lan									
sic	Part ff. Other algnificant conditions co	ntributing to death but no	t resulting in the u	underlying	ceuse giv	ven in Part f.	23b. Dfc	d tobacco use contril	bute to the cause of death?
F	MACNUTRITIO	M					t C	Yes 2 No 3	Probably 42 Unknown
by	MITCHAOLINIA	,							
Be Completed by Physician		للثبلب	100				24a. We per	s an autopsy 2 formed?	4b. Ware autopsy findings available prior to completion of ceuse of death?
Ē							10	Yes 25 No	1 Yes 2 No
Ö									1 163 2 100
	25. Was case referred to medicef examiner?	Hospitel:			Ott	her /	Beath (Check only		
2	TLI YAS ZIZNO	1 LI Inpatient	2 ER/Outpatie		DUA	4LA NUISI	-	sidence 6 Other (	Specify)
on	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28e. Dete of Injury (Month, Dey Yea	28b. Time o		28c. Inju Wo		28d. Dascribe	how injury occurred	
- C	2 Accident investigation			М		Yes 2□No			
() [	3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - building, etc. (S)	At home, farm, st pecify)	treet, facto	ory, office		28f. Location City or To	(Street end Number o own, Stete)	or Rurel Route Number,
ertific			knowledge deat	th occurre					
dical Certific	(Check only 2 Medical Exami	reician: To the best of my iner: On the basis of exa			on, in my o	opinion, death o	occurred at the time	, date end place, and	due to the cause(s)
Medical Certific	(Check only 2 Medical Exami			rvestigatio			occurred at the time		
edic	(Check only 2 Medical Exami	Iner: On the basis of exa- end manner steted.		rvestigatio	9c. Licens	se number		29d. Date signed (A	Month, Day, Year)
Medical Certific	(Check only 2 Medical Exami	Iner: On the basis of exa-		rvestigatio	9c. Licens	se number		29d. Date signed (A	Month, Day, Year)
	(Check only 2 Medical Example)  29b, Signature end title of certifier  29b, Neme and address of person who c	Iner: On the basis of examend manner steted.	mination and/or In	nvestigation 2	9c. Licens	se number		29d. Date signed (A	



State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #27 PER PHY G787 9-19-00 Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Vost **Physician** KING 8.10 PM WILLIAM AUBUST 2000 14 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GOOD SAMARITAN BALTIMORE HOSP ITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 6. Sex 1 Ø M 2 ☐ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys 222-10-3059 76 Director Aug 14, 1924 DEL Usual Residence of Decedent 10c. City. Town or Location 10b. County 10d. Inside City Limits N/A Baltimore 1 Yes 2 No Director 28a-f 10e. Street and Number 10f Zio Code 10g. Citizen of What Country? à 3754 Ravenwood Avenue 21213 238 Funeral 12. Was Decedent Ever in U,S. Ammed Forces?

1 △ Yes 2 □ No If Yes, Give Yeer or Dates: 143-45 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian. Black, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 ☐ No Specify: white Baltimore, Maryland 21215-0020 8 Specify: by 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiana. self employed game creator Pages 1 and 2 should be file.
Coepatiment of Health and Montal Hygh.
Amportant if them 27 is marked any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be unk unk 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5601 Loch Raven Blvd Baltimore, MD 21239 19a. Informant's Name/Retationship (Type, Print) Good Samaritan Hospital 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) In State 21. Signeture of Funeral Service Licenses Ronald S. Wade, Director 22. Name end Address of Facility
State Anatomy Board 655 W. Baltimore Street 21201 Lall Baltimore, MD ullen 23a. Part. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart leilure. List only one cause on each line. Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 5 DAYS SEVERE SEPSIS Examiner' Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or tnjury Due to (or as a consequence of) requires that the death certificate be exec Box 68760, that initiated events resulting in death) Last Due to (or as e consequenca of): P.O. Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ISCHEMIC CARDIOMYDPATHY Division of Vital Records. py 24b. Were autopsy lindings eveilable prior to completion of cause of death? Be Completed 24a. Was en autopsy CHOLANGIDCARCINOMA performed' 1□ Yes 2No 1 Yes 2 No Hospital or Attending Physician: 24 hours after death... Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at ... Work? 5 Pending Investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 SuicIde 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 29a Certifier TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

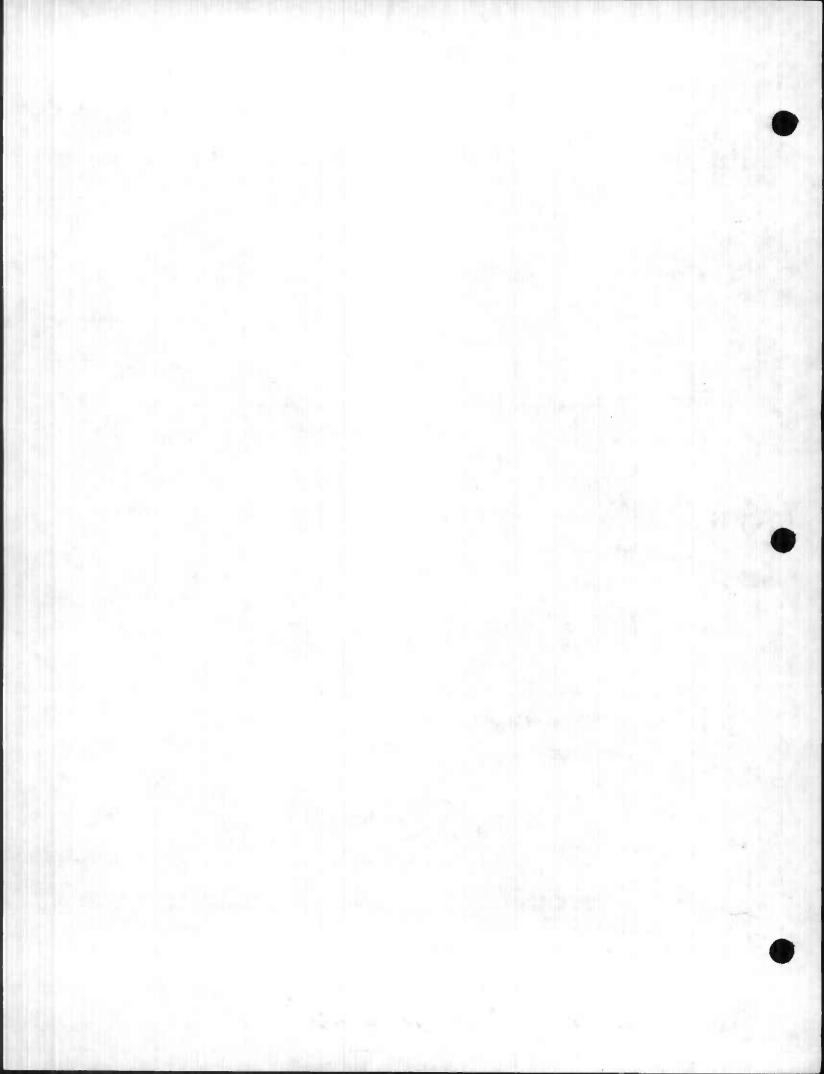
2 Medical Examiner: On the basis of examination and/or twestigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature end title of certifier P14420 AUGUST 14, 2000 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) HOSPITAL, BALTIMORE, MD REGINA OSIH GOOD SAMAR ITAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Ray 6/95

Registrar

SEP 1 9 2000

**ORIGINAL** 



State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #26 PER VERBAL RESPONSE GERTificate of Beather. 29449 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 25, 2000 **Physician** Kathleen E. Kearns 11:30 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4041 Lomar Drive Mt. Airv Frederick If Under 24 Hrs. 5. Social Security Number If Under 1 Year Birthplaca (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□ M 2QF 217-30-4375 Yrs. 81 Dec.8,1918 England Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. tnside City Limits 28a-f show must be notified at MD Baltimore 1 ☐ Yes & ☐ No Essex Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 602 Ross Street USA 21221 234 Funeral 1 and 2 should be filed within 72 hours after death Health and Mental Hygiene.
9m 27 is marked other than "natural", or flems 23. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White þ 3)K Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Clerk Convenience Store 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Bernard Igoe Ethe1 Farr 19a. Informant's Name/Relationship (Type, Print) 19b. Maiting Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If Nem 27 is any injury or other trauonce. Michael Zabkowski / son 4041 Lomar Drive MT Airy 20b. Place of Disposition (Name of cametery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2XDCremation 3 ☐ Removal from State Metro Crematory Inc. 8/30/2000 4 ☐ Donation 5 ☐ Other (Specify) Baltimore MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Essex 300 MAce Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or complications that caused the death. Po not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pl Tacit n Immediate Cause (Final disease or condition resulting in death) /Medi ,al Liver Failure Comminer Due to (or as a consequenca of): Physician/Medical Examiner Cirrhosis The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Renal Insufficiency Due to (or as a consequence of) use as the P.O. Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yae 2 ☐ No 3 ☐ Probably 4 ☑ Unknown of Vital Records, Medical Certification: To Be Completed by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 should 1 ☐ Yes 2 ☐No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) HOMES Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division To the Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 40307 August 28, 2000 rand sigere 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene B. Casagrande, M.D., 1564 Opossumtown Pike, Frederick, Maryland 21702

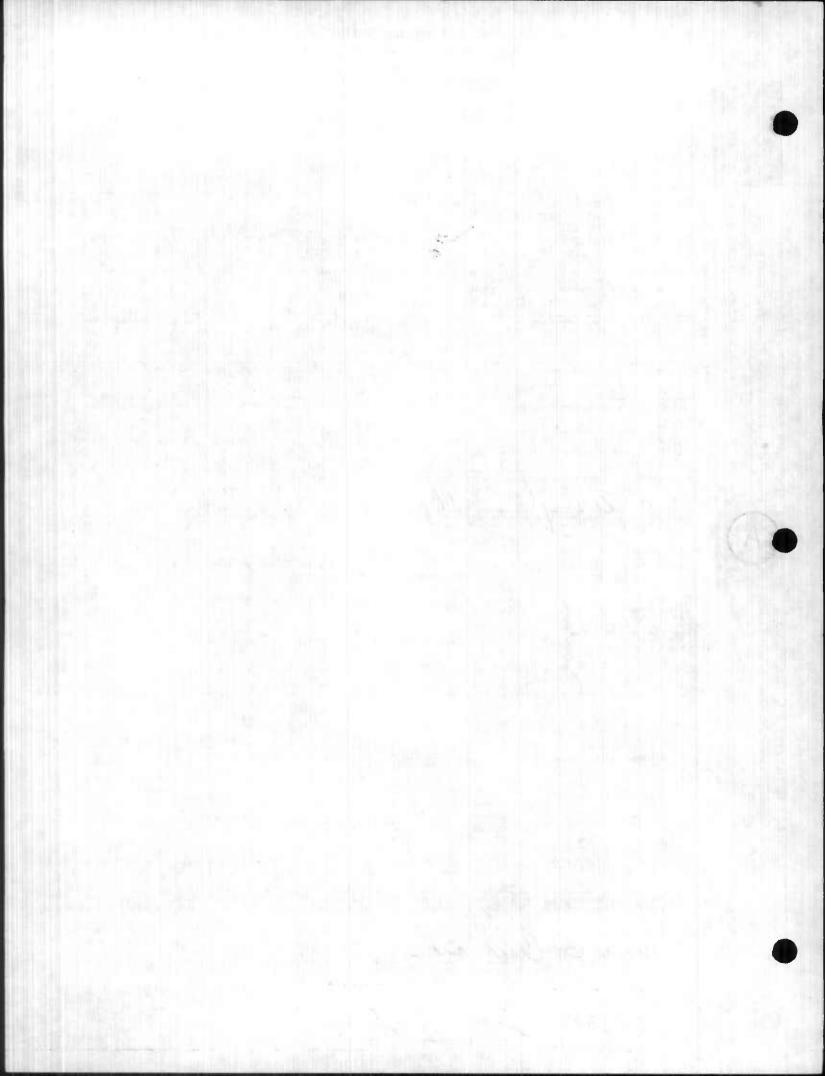
State Registrar

SEP 1 9 2000

31. Date filed (Month, Day, Year)

32. Registrar's Signature ooks

**DHMH 16 Rev 6/95** 



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29450 Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Deeth 6:05 AM SEPT. 15, 2000 ZANVYL KRIEGER 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 1 SLADE AVENUE, APT. #501 BALTIMORE BALTIMORE If Under 1 Yaar If Undar 24 Hrs. 5. Social Security Number 6 Sax 8. Data of Birth (Month, Day, Year) AFRIL 1,1906 7. Age (In yrs. last birthday) Birthplace (State or Foraign Country) Days ₩ M 2 F 94 Yrs. 214-34-3371 MARYLAND Usual Rasidance of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE BALTIMORE 1 Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 SLADE AVENUE, APT. #501 21208 U.S.A. Race - American Indian, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-ff Yes, specify Cuben, Maxican, Puerto Rican, etc.) TVYas 2 No If Yes, Giva Yaar or Datas: 1 Never Married 2 Married 1 ☐ Yas 2 ② No Specify: WII Specify: WEITE 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Cottege (1-4or 5+) 5+ ATTORNEY AT LAW 18. Mothar's Nama (First, Middle, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) HERMAN BETTIE KRIEGER FARBER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) BETSY KRIEGER / DAUGHTER 411 HAWTHORN RD., BALTIMORE, MD. 21210 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State N Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Other (Specify) ARLINGTON, CHIZUK AMUNO 09/17/00 BALTIMORE, MD 21. Signature of Funaral Sarvice License 22. Nama and Addrass of Facility SOL LEVINSON & BROS., INC. 23a. Part1. Entar the diseasa, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heer feilure. List only one ceuse on each line. MD 21208 Approximata Interval Between Onset end Death Immediata Causa (Final Metrutustra colon diseasa or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yae 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy parformed? 1 ☐ Yes 2 3 NO 25. Was casa rafarred to medical axaminar? 26. Place of Deeth (Check only ona) Hospitat: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Homa 5 Cooldence 8 Other (Specify) 1 Yas 2 LNO 27. Mannar of Death 28a. Data of tnjury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Panding invastigation 1 BNatural 1 Yes 2 No

**Physician** /Medical Examiner

Department important: If any injury or

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

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**Funeral** 

Director

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Attention

Pages 1 and 2 should be filed within 72 hours effer and of Health and Mental Hygiens.

Int: If item 27 is merked other than "natural; or ite ury or other traumatic avant, the indicat Essential ury or other traumatic avant, the indicat Essential.

Baltimore, Maryland 21215-0020

The law requires that the death certificate be axecuted buriel-transit pul Box 68760, the 080 signed by the a Division of Vital Records, P.O. this certificate or Attanding Physician: funeral director, after death.

Physician/Medical Examiner Completed by Be Certification: To 3

2 Accident

4 Homicide

(Check only

29b. Signature and file of cept

3 ☐ Suicide

29a, Certifier

within 24 hours a To the Funeral D Hospital edical completely the th

filled in

State Registrar

G. Auwaerter Falls

6 Could not be

10755

28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

29c. License number

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

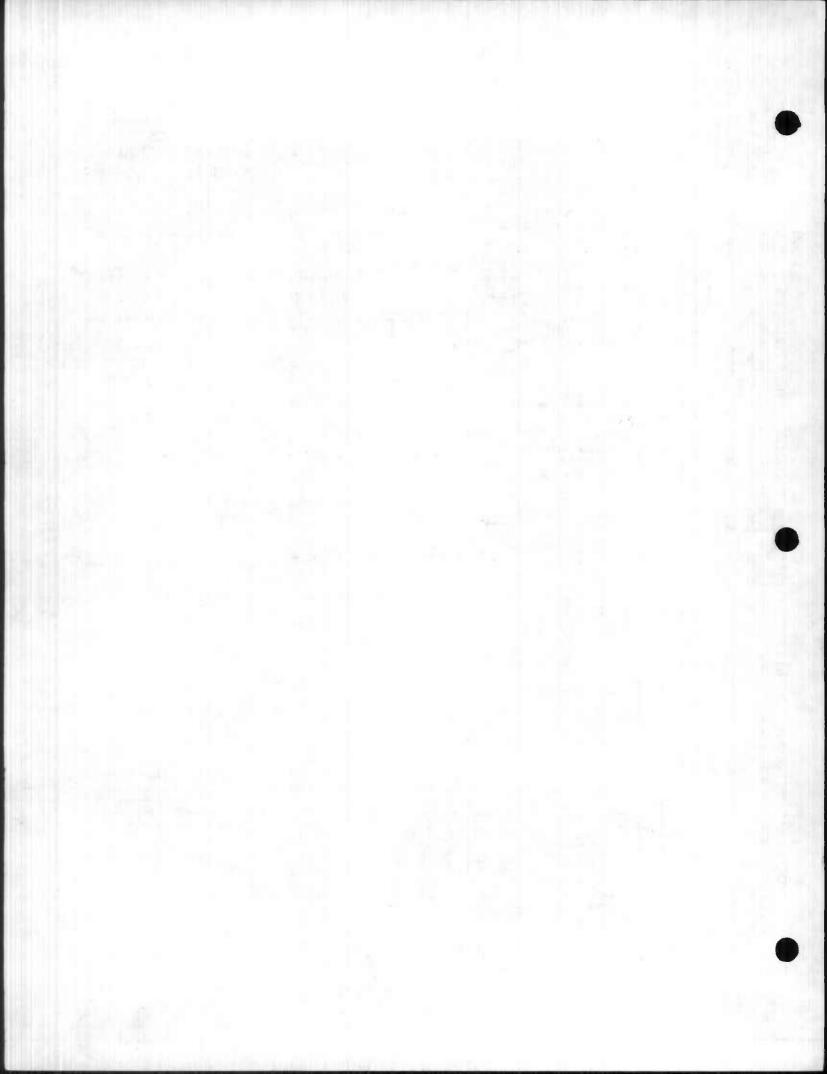
29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

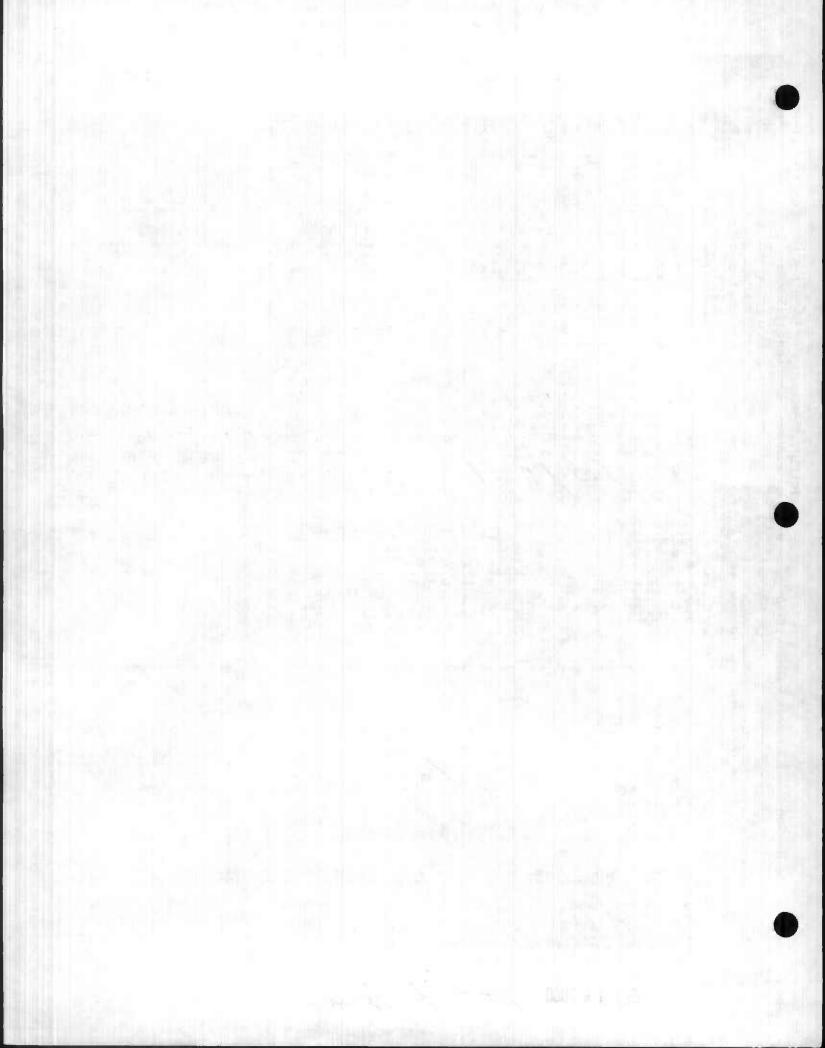
30. Nema end addrass of parson who completed causa of death (frem 23a) (Type, Print)

=360, Lutherville, MD 21093

32. Registra s Signatura 31. Data filed (Month, Day, Year)

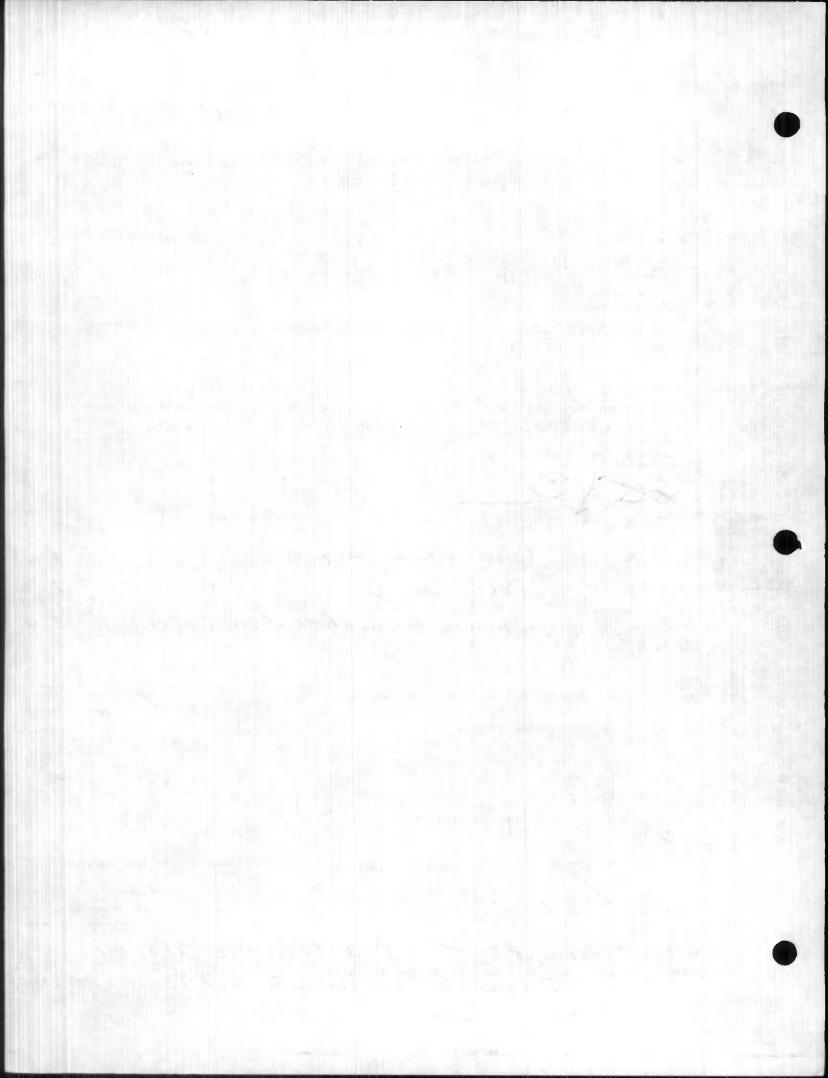


	State of M	laryland / Dep <i>Ce</i>	artment of I			iene	0 29451
	Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
Physician /Medical	Earl A. Klein				Sept. 1		
Examiner	4e Facility Neme (If not institution, give street and number	7)		4b. City, Town, or Loc	ation of Deeth	4c. County of	ot Death
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Funeral Director	1ÅM 2□F	ige (In yrs. lest birthdey 82 Yrs.	Months Deys	Hours Min.	8. Date of Birth (Month, Dey, Aug. 2,	1918	9. Birthplace (State or Foreign Country) Maryland
(d)	215-10-1662 Usuat Residence of Decedant	02			Aug. 2,	1510	Maryland
) 1 6 H	10a. Stete 10b. County	10c. City, Town or L	ocation			35 1/1 5	10d. Inside City Limits
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2000 with the Ma or 28e-1 s be mortified	10e. Street and Number		10f. Zip Code		10	0g. Citizen ot W	hat Country?
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5-0020 72 hours after death a matural, or thems 23s dical Examiner must sted by Funeral	11. Meritel Stetus  1 □ Never Married 2 □ Merried  3 □ Widowed 4 □ Divorced  12. Was Decedent Armed Forces 11. Yes 2 □ If Yes, Give Yeer or Detes:	] No	Wes Decedent of if Yes, specify Cub	Hispanic Origin? (Spec ean, Mexican, Puerto R Specify:	ary Yes or No- lican, etc.)		e-American Indian, k, Whita, etc. White
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Sand in the file of the sand o	Arthur Russell Klein			100000000000000000000000000000000000000	eth Bra		
Mary Mary d 2 shou th and M 7 is mark traumath	19e. tntormant's Name/Retationship (Type, Print)	19b. Mell	ing Address (Strea	t and Number or Rure!			State, Zip Code)
	Mr. Michael Klein/Son	P.0	. Box 219	Timonium	, Maryl	and 210	193
P. S. S. S. S. S. S. S. S. S. S. S. S. S.	20a. Mathod of Disposition	20b. Ptece of Disp	osition (Nema of emetory or other ple	ace)	Dete	20c. Location - (	City or Town, State
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Baltimore, Baltimore, semit. Pages 1a apparament of the reportant; if them my injury or other size.	21. Signeture of Funerel Service Licensee	2	2. Neme end Addr	ess ot Facility Ru	ck Tows	on Fune	eral Home, Inc.
702.00	muchael of Ruch	6	1050 Yor	k Road To	wson, M	arvland	
Physician /Medical Examiner	23a. Pert 1. Enter the diseese, or complications that cases shock, or haart taiture. List only one cause on each immediate Causa (Final diseese or condition resulting in deeth)	Due to (or as a conse	CANC				Approximate interval Between Onset and Deeth  5 months
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Sing I	27. Manner of Death  1 XNatural  5 ☐ Pending investigation  28a. Data of Inj (Month, D.)	ay Year) 28b. Time tnjury	Wo	ork? Yes 2 No	8d. Describe ho	w injury occurs	90 /
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State Registrar	SEP 1 9 2000	trar's Signeture	Source				



State of Maryland / Department of Health and Mental Hygiene 00 291.50

				Ce	rtificat	te of	Death			Reg. No.	5 4	3406	
	11-01-0	1. Decedent's Nama (First, Middla, Les	it)						2. Data of Dea		Year 3.	3. Time of Death	
	Physician /Medical	Anna E. Kno	x						SEPT		000	3:40 an	
	Examiner	4a Facility Name (If not institution, give	street and number)				4b. City, Tov	vn, or Loc	alion of Death	4c. County of	Death		
V		Union Memorial I	Hospital			E	Baltimo			n/a			
	Funeral	5. Social Security Number 6. S	ex 7. Age (In yrs.		If Unde Months	r 1 Yaar Days	If Undar 2 Hours	24 Hrs. Min.	8. Data of Birt (Month, Day	, Year)	Birthpiace	e (Stata or Foraign	
	Director		□M 2□F 85	Yrs.						17 1914		yland	
	2 .	Usual Rasidence of Decedent  10a. Stata 10b. County	10c C	tv. Town or Lo	vetion						104	Inside City Limits	
	show show											1 ☐ Yes 2 ☐ No	
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lar	id be so in o	John G. Beyne	on				Anr	na Ri	Ritter Pusch				
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2	2292	Alexander E. Kr	nox/husband	6 At	henr	y Ct	., Un	it 20	4, Tin	nonium,	MD 21	1093	
re,	of the other	20a. Mathod of Disposition		Place of Dispo	sition (Na	ma of	ce)	0/1	Dete 6/00	20c. Location - C	ity or Town,	State	
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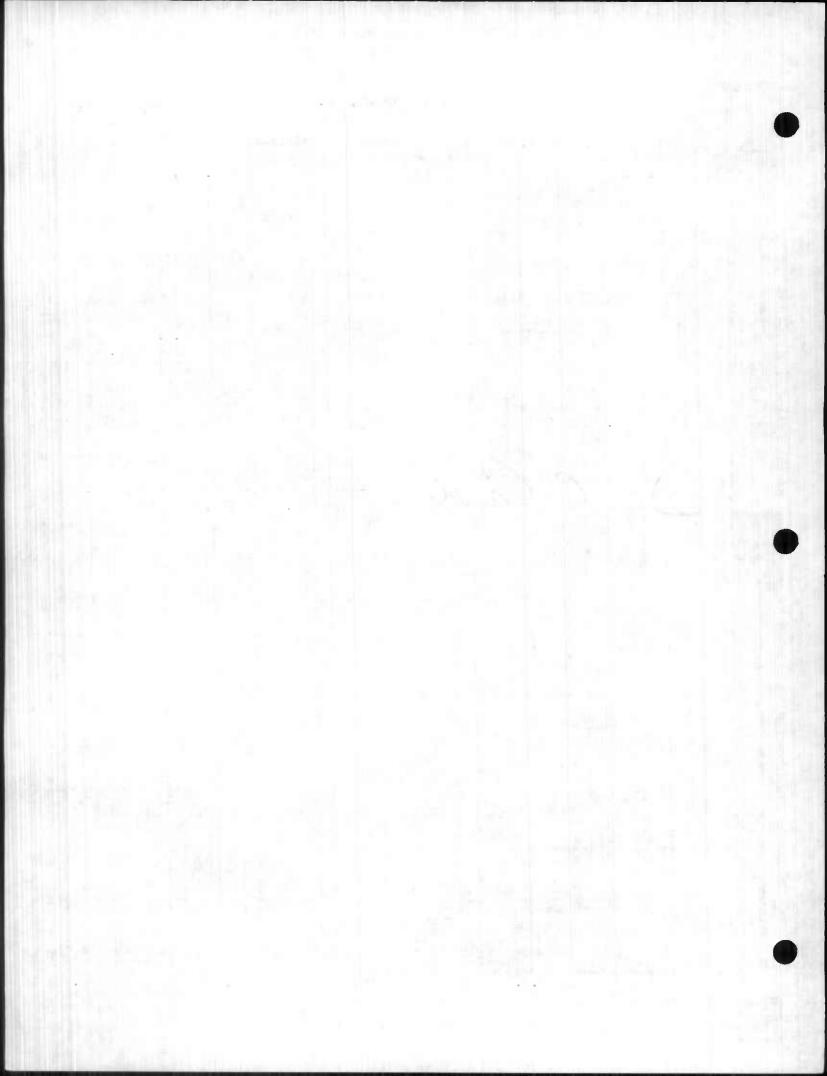


State of Maryland / Department of Health and Mental Hygien

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Manner of Death	Pending investigation	28a. Date	of Injury	28b.			Bc. Injury Work	rat c?	28				,
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**ORIGINAL** 



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ANTHONY 5:31 Pm 9 00 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE BALTIMORE MEDICAL CENTER MERCY ff Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1♥M 2□F Months Days Hours Yrs. **Director** 209-14-9793 APR 20, 1927 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Maryland Baltimore 1 X Yes 2 □ No Director 288-4 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n Berns 23a 1815 Gough Street 21231 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 O 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1941 1 Ves 2 No 1941 If Yes, Give Year or Dates: to 1945 1 Never Married 2 Married Baltimore, Maryland 21215-0020 'natural', or 1 ☐ Yes 2 ☑ No Specify: Specify: White À 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Seaman Merchant Marine 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be should be and Mental Wasyl Lyba Veronica Bialis semil. Pages 1 and 2 sh.
Department of Health and N.
Importants if then 27 is manany Injury or other. 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Irene Lyba/Wife 1815 Gough Street Baltimore, MD 21231 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-18-00 Metro Crematory Inc. Baltimore, MD 21. Signature of Funeral Service Licensee

Thomas Gregor 22 Name end Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, 21228 MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examine attending physician and for use as the burla-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events be executed PERTENSION thet initieted events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 40 Unknown of Vital Records, by 24a. Was an autopsy performed? 24b. Were eutopsy findings available prior to Completed completion of cause of death? page 1 Yes 1 Yes this certificate Be 25. Wes case reterred to medical 26. Plece of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Dey Year) Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t Division Attending 5 Pending investigation s after dea...al Director: Aftv 1 Yas 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, tectory, offica building, etc. (Specify) 4 ☐ Homicide 8 24 hours Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and dua to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated. edical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Dete filed (Month, Dey, Year) TU MI 32. Registrar's Signature State Registrar 1 9 2000

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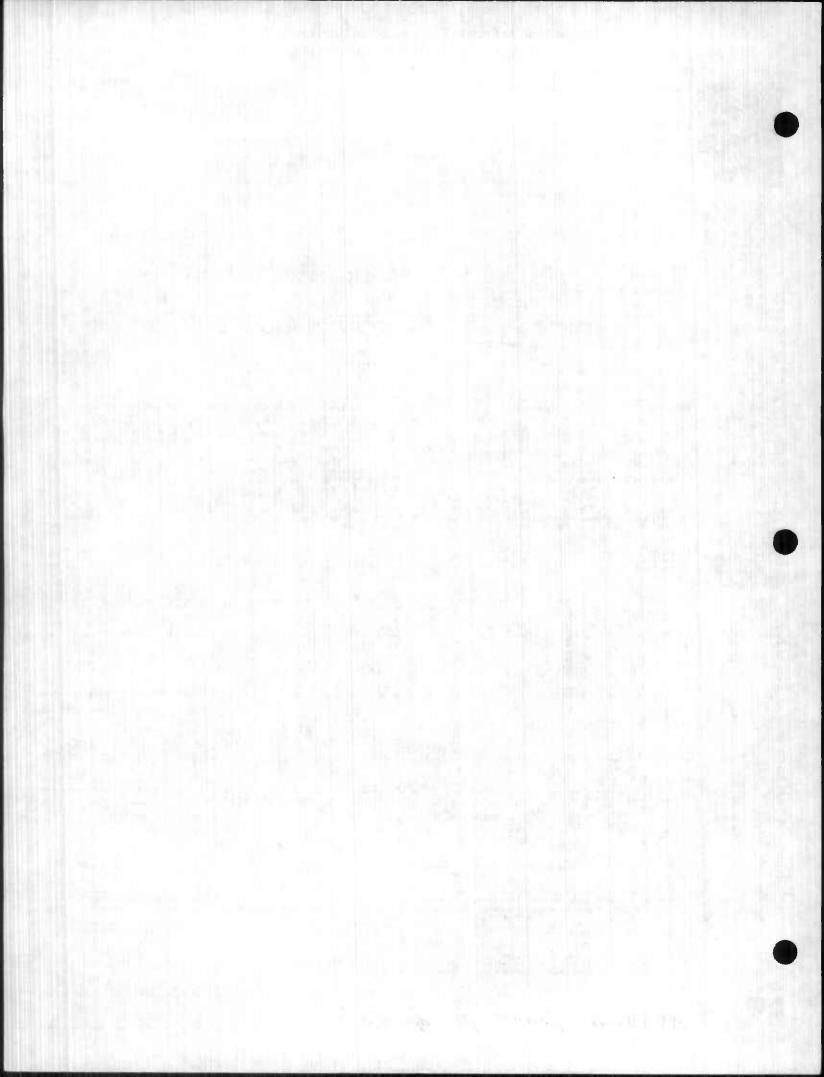
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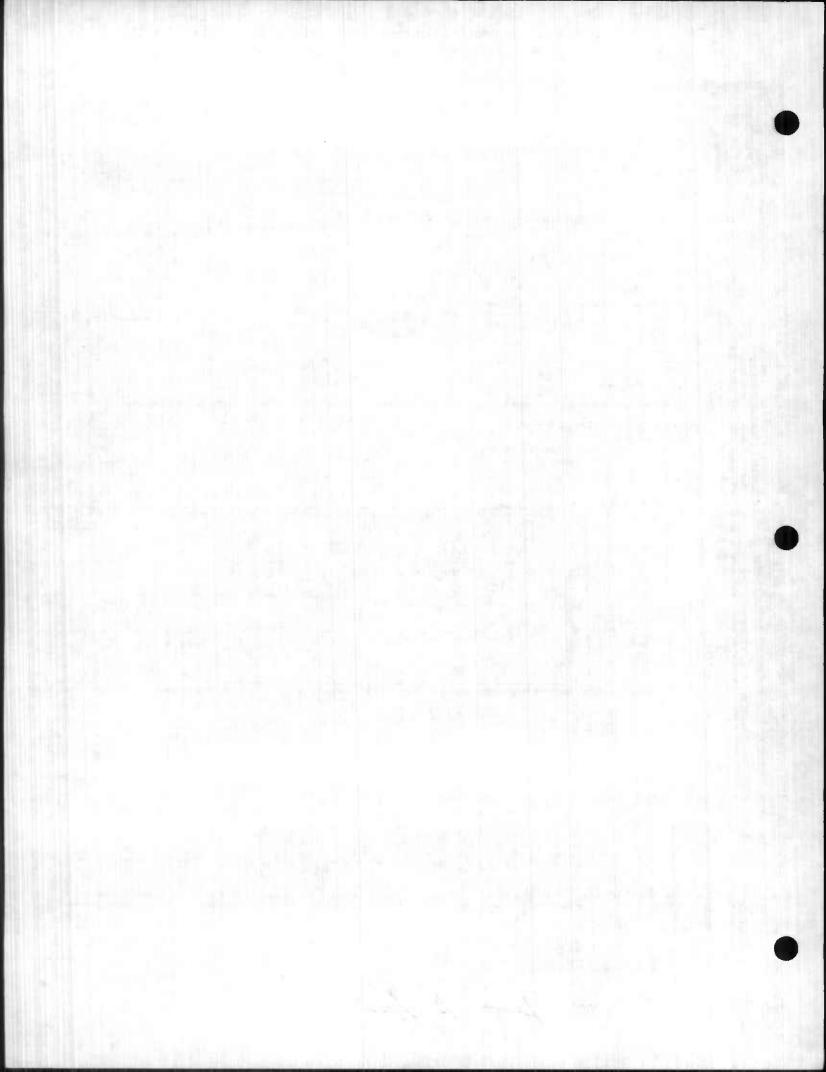
State of Maryland / Department of Health and Mental Hygiene 00 29155

		Certificate	of Death	Reg. N	No.	29455
Street in law	Decedent's Name (First, Middle, Last)			Date of Death Month	Day Year	3. Time of Death
Physician /Medical	YVONNE C. LEE  4e Facility Neme (If not institution, give street end n	number)		EPT. 1	1.1, 2000 4c. County of Death	
Examiner	4540 N. ROGERS AVE	iumber)	BALTIMO		N/	
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) If Under 1		Dete of Birth (Month, Dey, Yea		place (State or Foreign ntry)
Director	577-58-9500 1 M 20(F	59 Yrs. Months		7-27-41		INGTON, DO
with the Maryland a or 28e-f show De notified at Director	10a. Stete 10b. County	10c. City, Town or Location	The Part of			10d. Inside City Limits 11 Yes 2 □ No
28e.f.s solified ector	MD N/A	BALTI 10f. Zip C		100.0	Citizen of What Cou	
Dir Dir		Tot. Zip C				wwy.
w 23s must 3	4540 N. ROGERS AVE	ecedent Ever in U.S. 13. Was Decede	21.21.5		J.S.A.	can Indian
UZU urs after death af, or theme 23 Example, must by Funeral	Armed	s 27 No Give 1 ☐ Yes 2	nt of Hispanic Origin? (Specify y Cuben, Mexican, Puerto Rica XNo Specify:	in, etc.)	Black, White,	, etc.
21215-0020 ed within 72 hours at yoliens. or than "natural", or i, the Medical Exam Completed by I	15. Decedent's Education (Specify only highest grade completes	16a. Decedent's Usual (Give kind of work life. DO NOT use	Occupation done during most of working retired)	16b.	Kind of Businass/In	ndustry
the the	Elementsry/Secondery (0-12) College 1. 2	(1-4or 5+) HOMEMAKE	R		SELF	EMPLOYED
De file to other went,	17. Father's Neme (First, Middle, Last)		18. Mother's Name (Fi	rst, Middle, Maid	len Sumame)	
Menta Menta Menta Menta Menta Milicen To B	BENJAMIN LEROY CREE	EK	FLORINE H	AWKINS		
and and and and and and and and and and	19e. informent's Name/Raletionship (Type, Print)		Street and Number or Rural Ro	,		
and 27	CURTIS LEE, SON	4540 N. R	OGERS AVE, 1	BALTO.	MD 212	07
Pages 1 nert of Ha	20e. Mathod of Disposition  1 3 Buriel 2 Cremetion 3 Removel from		er plece)		Location - City or T	
Pich P	4 ☐ Donetion 5 ☐ Other (Specify)  21. Signeture of Funeral Servica Licensee	ARBUTUS MEMO	RIAL PK (19- Address of Fecility	-16-00	ARBUTUS	, MD
D Per D	111 0/1/2 5 1/2		L FUNERAL HO	OME		
HIE CHARGE	23e. Pert1. Enter the diseesa, or complications that shock, or haart failura. List only ona causa or	4600	LIBERTY HGH	TS AVE	BALTO.	MD 2120'
Physician /Medical Examiner	b.	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	e Conge	tive		Onsat and Death
fficate be g physicia as the bur edical	Sequantially list conditions, if eny, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or es a consequence of):	wà.			
the death cer whe attendin sched for usa	Part II. Other algnificant conditions contributing to	death but not resulting in the underlying cau	usa given in Pert I.	23b. Dld tobac	co use contribute (	to the cause of death?
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The law requires that the law requires that the has been signed to page 2 should be det	nisease			24e. Wes en eu parformed'	? a	Vera autopsy findings vailabla prior to ompletion of cause f daath?
r VItal Rec yelden: The law s certificate has b director, page 2 s To Be Comple	Essential Hyr	pertension.		1 🗆 Yes	2 No 1	☐ Yes 2☐ No
pertific sctor,	25. Wes case referred to medical axaminar?		26. Pleca of Death (C	heck only one)		
Physician: this certificinal director, TO Be	1 ☐ Yes 2 ☐ No Hospital: 1 ☐	Inpatient 2 ER/Outpatient 3 DOA				ify)
ing P unera unera	- Citatoroi		Work?	. Describe how in	njury occurred	
UNISION OF VITAL RECORDS, To the Hospital or Attending Physician: The law requires the within 24 hours after death.  Within 24 hours after death.  Within 24 hours after death.  Completely lilled in by the funeral director, page 2 should be a Medical Certification: To Be Completed by	2 Accident investigation 3 Suicide 6 Could not be datarmined 28e. Ple buil	ce of Injury - At home, farm, street, fectory, Iding, etc. (Specify)	1 Yes 2 No offica 28f.	Location (Street City or Town, St	l end Number or Rui data)	rel Route Number,
Hospi 4 hou Funer tely lii	(Check only 2 Medical Examiner: On tha	ha best of my knowledga, daath occurred at besis of examinetion and/or invastigation, i enner stated.				
within 2 To the comple	29b. Signature and title of certifler	29c.	License number	29d. [	Data signed (Month	
	Med BKion	2 cm les	57976		8/18	00
3	30. Neme and address of parson who complated ca	use of death (Item 23e) (Type, Print)	Keruille.	Tank.	16 lus	061



State of Maryland / Department of Health and Mental Hygiene

						Cei	rtificate	e of	Death		F	eg. No.	U	29456
	<b>D</b>		1. Decedent's Nama (First, Middle,	Last)		4 1175	5			Tale of	2. Date of Dea		Year	3. Tima of Deeth
-	Physiciar /Medica		CIPACE	LE	77	ANE					SEPTE	MBERLI	2200	2 5 75
	Examine	r	4a Facility Name (If not institution,		)						cation of Death	4c. County		
			Northwest Hos				I WALL	4.34			stown	Bal		
1	Funeral Director		216-05-7199	Sex 7. A	ga (In yrs. i	last birthday) Yrs.	If Undar Months	Days	If Undar Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 04 1.	3 Year)	9. Birth	place (State or Foreign
	2 k.	-	Usual Residence of Decedent  10s. State 10b. County		10c. City	y, Town or Lo	ocation							10d. Inside City Limits
	fam)	5	MD NA		Ва	ltimo	re							1 No Yas 2 No
	or zhafa	2	10e. Street and Number				10f. Zip	Code				Og. Citizen of V	Vhat Cou	untry?
			1905 Wheeler	Ave				21	216			U.	S.A.	
	death mas 2	runera	11. Marital Status	12 Was Decedent	Evar in U,	S. 13.	Was Deced	lent of I	lispanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)			ican Indian,
Maryland 21215-0020	ore o	23	1 Nevar Married 2 Married 3 Widowed 4 Divorced	Armed Forces'd  1  Yes 2  If Yes, Give Year or Dates:	No		1 ☐ Yes 2				nicali, etc.)	Specify	k, White	lack
5	72 h nahu dical	combiened	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usua kind of wor	k done	during mos	t of work	ing	16b. Kind of Bu	siness/li	ndustry
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12			12th grade  17. Fathar's Nama (First, Middla, L	6 yrs			Teac	ner		ar's Name	e (First, Middle,			CILY
and	Hall De H	ō.	John Scott	31/					1000		Scott	Walcoll Collien	۵/	
2	though the state of the state o	2	19a. Informant's Name/Relationshi	(Type Print)		19h Maili	na Address	/Stree			al Route Numbe	r. City or Town.	State. 7	in Code)
M	nd 2 all h ar 27 is r trau						_				Baltime			1216
re,	Tan Tan Tan Tan Tan Tan Tan Tan Tan Tan		Charles Smith 20a. Method of Disposition	-rrieno	20b. P	lace of Dispo	osition (Nan	ne of			Date	20c. Location -	City or T	Town, State
OE	A HOLE		1  Burial 2  Cremation : 4  Donation 5  Other (Sp.		9	emetery, cres				ark	9/18/	A 0005	rhu	tus, Md
altimore	and a series	-	21. Signature of Funeral Service Li		AL	22	2. Name an	d Addre	ess of Facili	ty	9/10/	2000 A	LDU	cas, na
B	SQ N S		Hlynis	B. Ho	wi	2) 43		aba	ash A	ve,	Balti		d :	21215
20	0000		23a. Part . Enter tha disease, or of shock, or heart falura. List of	in mplications that cause if you cause on aach i	d the deeth line.	n. Do not ent	ter the mod	e ot dy	ng, such as	cardiac	or respiratory er	est,	1	Approximete Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final	(	5	0815							1	Onset and Death
0.	Examiner		disease or condition resulting in death)	8	SEI	817								
Н		5			Due to (o	res a conse	quence of):							
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ć	exect in an in all tra	LAS	if any, leeding to immediate cause. Enter Underlying		Due to (o	as a consec	querice or).							
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S,	the se of	2											1 041 1	
Records,	peen shou	Merce				P. Pari					24a. Was	med?	8	Were autopsy findings available prior to completion of cause of death?
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tai	certificate rector, pag	0	25. Was case referred to medical	T					26. Plec	e of Deet	h (Check only o		1	
of Vital	5 00		axaminer?	Hospital: Inpati	ient 2	ER/Outpaties	nt 3 DC	A Ot	hor		me 5 Resid		er (Spec	city)
0	After this funeral di		27. Manner of Death  1 Netural 5 Pending	28a. Date of Inj (Month, De	ury ay Year)	28b. Time o	of 2	8c. Inju	ry at		28d. Describe h	ow injury occur	red	
Division	tal or Attending P rs after death. al Director: After t led in by the funera		2 Accident investige	tion			М	1[	Yes 2	No				
Σ	or Attender de Directo		3 Suicide 6 Could no determin	289. Place of In	njury - At ho	me, ferm, st	reet, factory	, office			28f. Location (S City or Tow		er or Ru	iral Route Number,
0	ital or afte													
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Directors After Completely filled in by the funeral for the funeral for the funeral formal f	200	29a. Certifiar (Check only one)  Certifying  2 Medical E	Physician: To the best taminer: On the basis of and mannar si	of examinat	wledge, deat tion and/or in	h occurred avastigation,	at the t	ime, date ar opinion, dec	nd place, oth occur	and dua to the cred at the tima, c	ause(s) and ma lata and placa,	and due	stated. to the cause(s)
	within 2 To the comple	-	29b. Signeture and title of certifier	1			290	. Lican	sa number			29d. Data signe		
	1			ente				1)	37:	777	5	EPTE	418	n12,2000
0	20,9	-	30. Nama and addrass of person w	no completed cause of	death (Item	23a) (Type	Print)		3 / -		1133			
0	17		C. 1	NIMO.	NH	e, 1	CALT	0.	M	2	1133			
	State		31. Date filed (Month, Day, Year)	32. Regist	rar's Signa	40	lon V	1						
	Registra	_	SEP 1 9 2000	peneg	1	19	vou.							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #17 PER INFORMANT G787 9-20 Micate Of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month September 15, 2000 9:35 AM **Physician** George Warren LOWE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Baltimore 3703 Old Milford Mill Road Pikesville If Under 24 Hrs. | 8. D 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1₩ M 2□ F 219-03-4967 84 Yrs. **Director** February 20,1916 Maryland Usual Rasidence of Decedant the Maryland r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Pikesville Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Examiner man be 21208 United States 3703 Old Milford Mill Road Funeral filed within 72 hours efter death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 XYes 2 ☐ No If Yas, Give Year or Dates: Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐XNo Specify: þ 3 Widowed 4 Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry then al Hygiene. Elemantary/Secondary (0-12) College (1-4or 5+) Westinghouse Machinist 6th. 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be 1 end 2 should be fi Health and Mental H em 27 la marked ott WILBUR LOWE Wilbur John Lowe Nettie Hughes 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (son) 1304 Buckhorn Rd. Sykesville, MD 21784 item 27 le Mr. George L. Lowe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
important: If iter
any injury or oth 1 Denial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Woodlawn Cemetery Sept. 18, 2000 Woodlawn, Maryland 22. Name and Address of Facility Loring Byers Funeral Directors, Inc 8728 Liberty Road, Randallstown, Maryland 21133 ellner NOG 333 plustions that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner dua to (or as a consequence of): Examine enteuseo be executed Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last physician s the burial distascular differen thewschol COU Physician/Medical Due to (or as a consequence of) Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 ☐ No 3 Probably 4 Unknown P 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case raferred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 No 5 Residence 6 Othar (Specify) Medical Certification: To this 27. Manner of Death 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

Box 68760, P.0. Records, of Vital Division

To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

State

3 Suicide

29a. Cartifiar

4 Homicide

29b. Signature and title of certifier

ROSSROADS

Registrar

31. Date filed (Month, Day, Year) 9 2000

AB

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

6 Could not be

OWINGS 32. Registrar's Signature

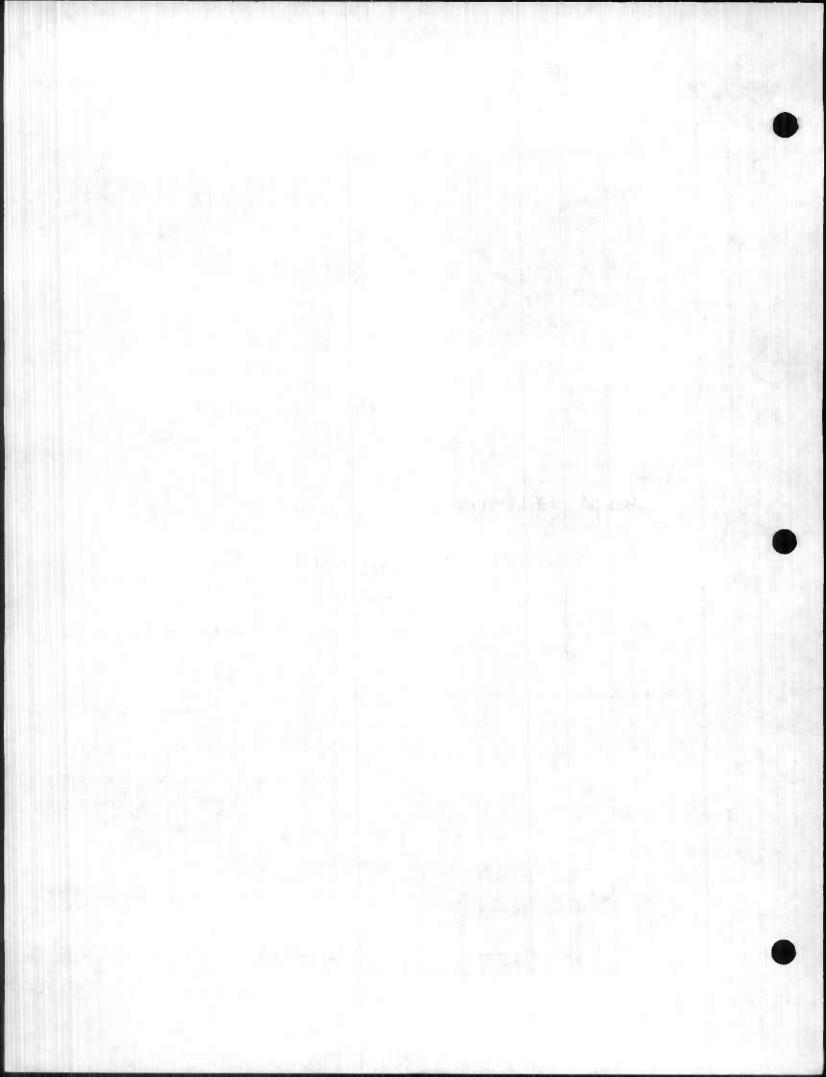
28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

29c. License number

\*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

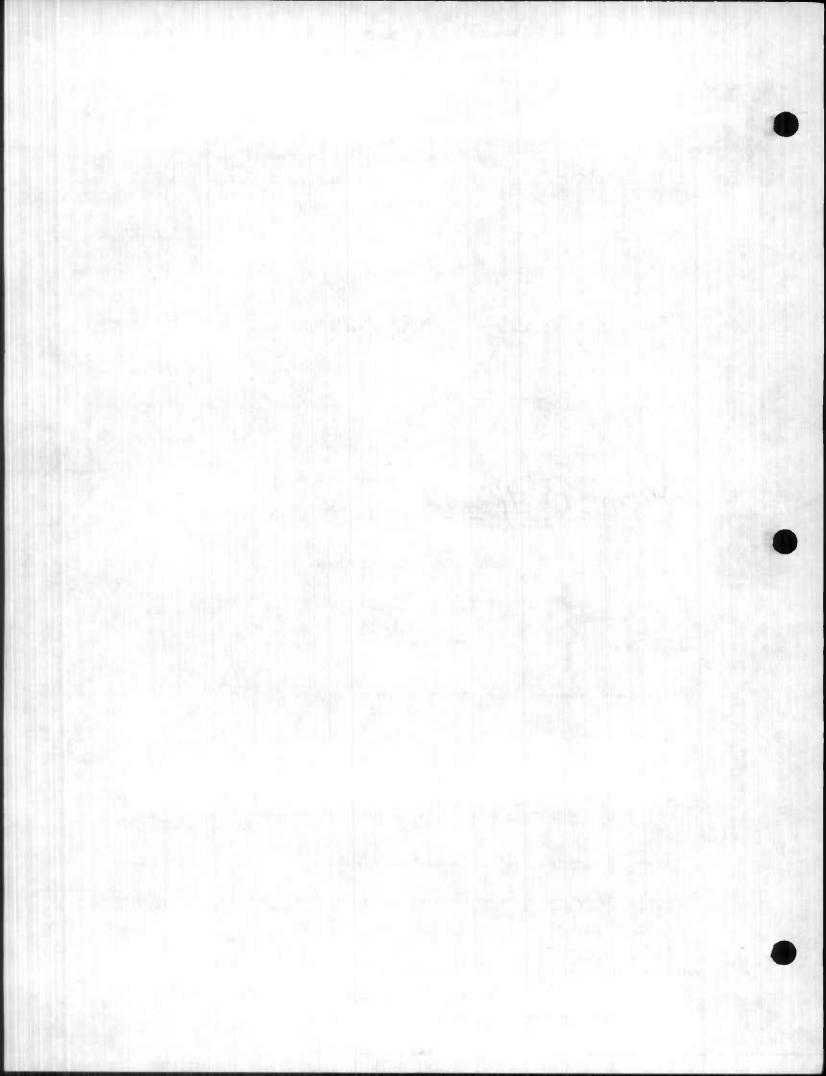
29d. Date signed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene

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				C	ertifica	ate of	Death		Rec	a. No.			
	Dharataian	1. Decedent'e Name (First, Middle, La						2	2. Date of Death Month	Day	Year	3. Time of D	Death
	Physician /Medical	James R.	Lindley	, Sr.					Stopsema	1 1 0	OUO	33:50	1 pm
7	Examiner	4a Facility Name (M not institution, gh Union Memoria	re street end number) L Hospital				Balt		ation of Death	4c. County	A Death		
	Funeral Director	218-26-9843	Sex 7. Age (III	n yrs. last birthde 9 Yrs.	Month	der 1 Year is Days	If Under 24 Hours	4 Hrs. 8	Dete of Birth	(4/930	9. Birthp	ryland	Foreign
	Pue	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or	Location						11	IOd. Inside City	/ Limite
	vith the Maryle t or 28a-f aho be nowhed at Director	Maryland N/A		Baltim	ore							XX Yes	
	after death with the Marylen or Herns 23a or 28a-f show miner must be notified at Funeral Director	10e. Street end Number 2732 Huntingdo	on Avenue				21211				ISA		
21215-0020	o Cris	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1∑Xes 2 ☐ No If Yes, Give Year or Dates:	r in U,S. 1		pecify Cube	ispanic Origin n, Mexican, I Specify:	n? (Speci Puerto Ri	ify Yes or No- can, etc.)	Black	- Americ k, White, Whi	can fndian, etc. te	
5-0	ed within 72 hours ygiene. or than "natural", r, the Completed by	15. Decedent's E (Specify only highest gri		16a. De (G	cedent's Usive kind of	sual Occup work done	ation during most o f)	of working	7	6b. Kind of Bu	siness/in	duatry	
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	Hygiene. Hygiene. Hygiene. Hygiene. Hygiene. Hygiene. Hygiene.	1 0 17. Father's Name (First, Middle, Last	)	01	I Du	THE			First, Middle, M			uny	
an	Mental Hyg mrked other artic event, To Be C	THE REAL PROPERTY OF THE PARTY							lian Ma				
Maryland	4 DEE	19a. Informent's Name/Relationship (		19b. Me	elling Addre	ess (Street			Route Number,			Code)	
M	0 0 0 0	Phyllis Lindle							enue, Ba				1211
Baltimore,	of He	20a. Method of Disposition  1	Removal from State	Dob. Place of Discometery, of Balto.	remetory o	r other place	emato ton	ry <sub>9/</sub>	Date 20 /18/00	Laure			and
Balti	permit. Pag Department Important: I eny Injury o page.	21. Signatury of Funeral Service Leg	3 0 V		Burg	ee-H	ss of Facility	Seit	tz Fune	eral H	lome	212' Inc.	
		23a Parti Erver the disease, or com shock, heart failure. List only	plications that caused the	death. Do not	3631 enter the m	Fal ode of dvin	ls Ro	ardiac or	Baltin	nore,	Mar	yland	
	Physician	shock, w heart failure. List only	one cause on each line.								-	Interval Betwo	reen
7	/Medical	Immediate Cause (Final disease or condition	1/20/2	- 0 1 -	0 0 -	A						3	110
	Examiner	resulting in death)	e. Ov O(L	Mario e to (or as a con	sequence o	of):	me				1	SIVOL	ichi
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	deeth certificate be executed e ettending physician and id for use as the bunal-transit siciar/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due Due	o to (or as a con	sequenca o	of):		J-1					
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0		Part II. Other significant conditions of	contributing to death but n	ot resulting in the	e underlying	g cause giv	en in Pert I.		1 Ye	V	3 □ Pro	o the cause of	Jnknown
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ta	certificate rector. pag	25. Was case referred to medical					26. Place o	of Death (	Check only one	)			
>	N 0 0	examiner?	Hospital: Inpatient	2 ER/Outpe	tient 3	DOA Oth	O.P.		e 5 Resider		er (Speci	fy)	
o uoi	Attending Ph octor: After th by the funeral	27. Manner of Death  1 SNetural 5 Pending 2 Accident investigatio	28a. Dete of Injury (Month, Dey Ye	28b. Time Injur		28c. Injur Wor 1 🗆	yat k? Yes 2 □ Ne		3d. Describe how	w injury occurr	ed		
Division	Paris Paris	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (5		atreet, fact	tory, office		28	8f. Location (Street) City or Town,	eet and Number Stete)	er or Run	al Route Numb	ver,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by Medical Certiff		ysician: To the best of miner: On the basis of exi and manner ataled	amination and/or									
	Within To the comp	29b. Signeture and title of certifier			1	29c. Licens	e number		29	d. Date signed	(Month,	Day, Year)	
	NV	1/1	2			AT 2	422	941	, 5	rup - r	v 1	U 200	
-1	Wy /	30. Name and address of person who	completed cause of death	(Item 23e) (Typ	pe, Print)		. , 00			- Weiner	W 1	1,000	0
C	*	Chernl Person	M.D. 3	101 E.1	Univ	mrs:4	in Par	-KW	m. Bal	ratent timore	M	0 212	-18
	State Registrar	31. Date filed (Month, Day, Year)	32. Registrars	Signature	8	hoo	it's	**			/		



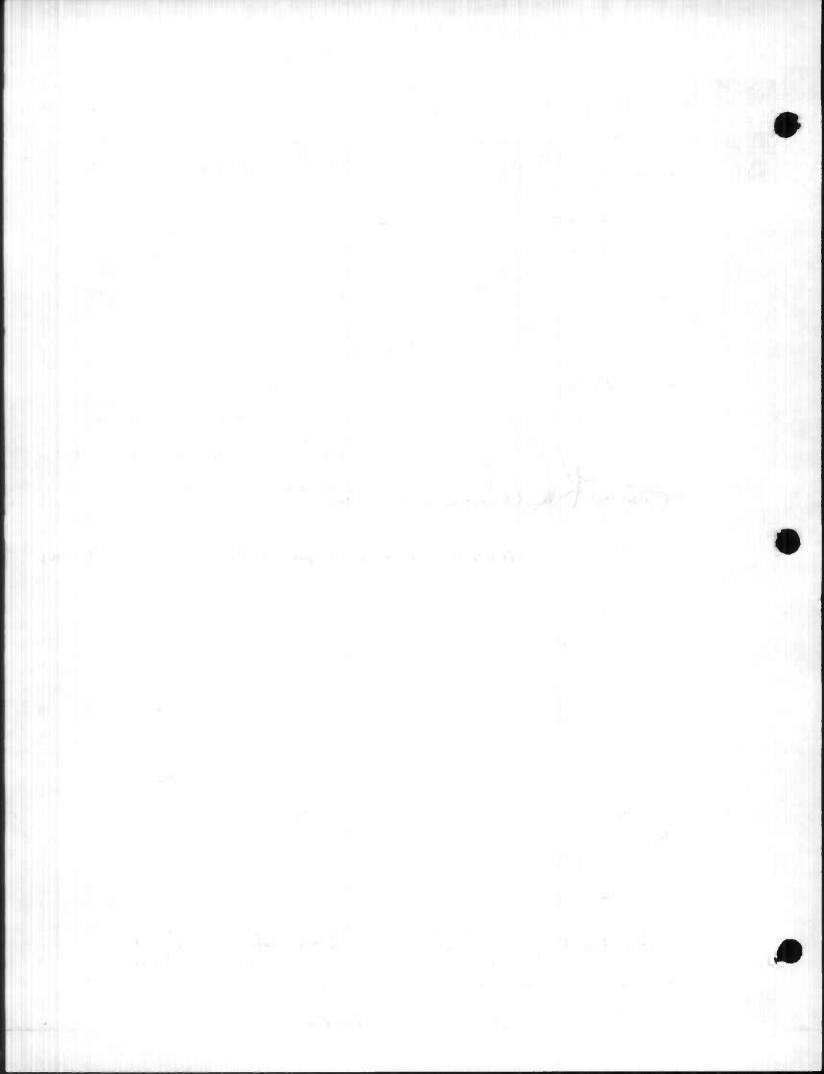
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** EUGENIA MESKAUSKAS AUG 29, 2000 6:30 PM /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MANOR HEALTH CARE OF KENSINGTON KENSINGTON MONTGOMERY If Under 1 Year 8. Date of Birth (Month, Dey, Year) SEPT 6, 1916 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign Country)
RUSSIA **Funeral** Days 1 □ M 2 ☑ F Months Hours Yrs. 350 28 0517 83 Director Usual Residence of Decedent with the Meryland 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No FLBROWARD POMPANO BEACH 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2601 NE 14th STREET #334 33062 U.S.A. death 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ဩ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) Race - Amarican Indian, Black, White, atc. 72 hours efter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: WHITE ò 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Peges 1 end 2 should be filed within nent of Health end Mental Hygiene. nt: If Item 27 Is marked other than Etementary/Secondary (0-12) HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN KUCINSKAS EMILY SCHOSSER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) ROCKY MESKAUSKAS - SON 634 VINTAGE RESERVE CIRCLE NAPLES, FL 34119 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State permit. Pege Department of Important: If any injury or once. NATIONAL CREMATORY 9/15/00 FALLS CHURCH 4 Donation 5 Other Specify 21. Signature of Funeral Sen 22. Name and Address of Facility AFFORDABLE FUNERAL SERVICES P.O. BOX 542 MERRIFIELD, VA 22116 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat failure. List only one cause on each line. Approximate Interval Betw Onset and Death **Physician** /Medical Immediate Cause (Finat disease or condition resulting In death) DENGNTIA ALZHEIMER'S Examine Due to (or as a consequence of): physician end s the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical Due to (or as a consequance of): 80 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Š 1 Yes 2500 3 Probably 4 Unknown signed d be del by 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy peen page 2 certificate 1 Yas 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 10 Other: Other: 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of To the Mospital or Attending Privithin 24 hours effer death.
To the Funeral Director: After the completely filled in by the funeral 28c. Injury at Work? 28d. Describe how Injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 3 Sulcide 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifian 29c. Licansa number 29d. Date signed (Month, Dey, Year) D08944 3720 FARRAGUT AVE. KENSINGPON NO 20895 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAKEW C. SHA-RGE 31. Date filed (Month, Day, Year) 32. Registrads Signature State

DHMH 16 Rev 6/95

Registrar

SEP 1 9 2000



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician September 3,2000 10:54 AM Arrhur Henderson Murray /Medical 4e Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Doctor's Community Hospital Prince George's Lanham If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs **Funeral** Months Days Hours 1 M 2□ F Director 121-48-5855 March 11,1949 Trinadad Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Director MD Prince George's ma 23a or 28a-f Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13304 Keverton Drive 20774 U.S.A. Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black White, etc. filed within 72 hours after 1 Never Married 2 KMarried 1 ☐ Yes 2X No If Yes, Give Year or Dates: 21215-0020 1 ☐ Yes 2 No Specify: Specify: p 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Telephone Technichian Private Pages 1 and 2 should be filed w ment of treath and Mental Hygie ant if item 27 is marked other ti lury or other traumatic event, to Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be William Murray Teresa Webber Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Hinton Murray/wife 13304 Keverton Dr., Upper Mariboro, MD 20774 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State Union Bethel AME Cemetery 9.09.00 Brandywine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Latney's Funeral Home, Inc. 21. Signal artif Funeral Service Licenses Amportant in the contract in t CC0348 3831 Georgia Ave., NW, Wash., DC 20011 23a. Part1. Enter the diefese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final PNEUMONI A disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Examiner SCLEROSIS LATERAL MAYOTROPIC The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? P.0. 1 Yea 2 No 3 Probably 4 Unknown Records, à ate has been sign page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy performed? 2 No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after deal Funeral Director: 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 29a. Certifier t Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29c. License number
D47-664 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Shanew 09/04 a.D 12000 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) SOBHAN MITCHELLVILLE FD, #104, BOWIE, MD20716

**DHMH 16 Rav 6/95** 

State

Registrar

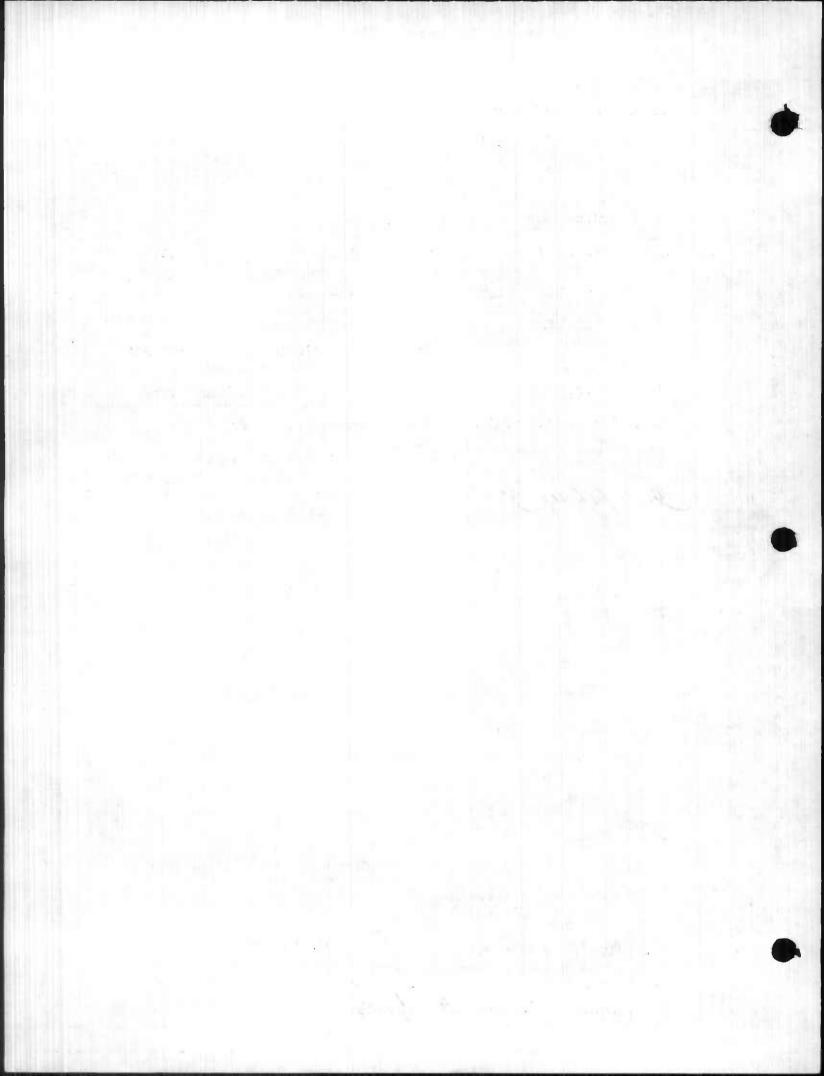
2905

MATHON

31. Date filed (Month, Dey, Year)

1 9 2000

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

29461 JOSEPH MCFADDEN Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 14, JOSEPH MCFADDEN SEPT. 2000 0816 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner BON SECOUR HOSPITAL BALTIMORE NA 5. Social Security Number If Under 1 Yaar Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2□ F Months Days Hours Yrs Director 1932 239-48-4409 Usual Residence of Decedent 68 September 4, 10a. Stata 10b. Count 10c. City, Town or Location 10d. Inside City Limits or items 23s or 25s-f show the Mary 1X Yes 2 No Directo MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iens. - than "natural", or items 23s or the Medical Examinar must be. 21223 USA 1732 W. Fayette Street Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - American Indian. Bleck, Whita, etc. African 72 hours after 1 ☐ Yes 2 ☑ No If Yas, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify. à 3 Widowed 4 Divorced American Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry should be filled within ind Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Construction 10th NA Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be marked William McFadden Fannie McFadden 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) ā Pages 1 and 2 s ment of Health an Health Hem 27 2506 Marbourne Ave Baltimore, MD 21230 Antoinette McFadden 20b. Plece of Disposition (Name of cemetery, crematory or other place) important: If its any Injury or oth 20a. Method of Disposition 20c. Location - City or Town, Steta Burial 2 Cremation 3 Removal from Stata
4 Donation 5 Other (Specify) Arbutus Memorial Park 9/21/00 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home PA 638 N. Gilmor St. Baltimore, MD shock, or heart failura. List only one information and caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cert and each line. Approximate Intervat Between Onset and Death Physician Immediate Cause (Finel disease or condition resulting in death) /Medical Arteriosclerotic Cardiovascular Disease Examiner Due to (or es a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed as the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last pue Due to (or as a consequence of): Box 68760. the attending physician Dua to (or as a consequanca of): 980 i signed by the aid to be detached for P.O. Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown by Division of Vital Records. 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed page 2 should INSPECTION this certificate has 1 ☐ Yes 2 ☐ No 1 Yes 2 No Physician: 25. Was case referred to medicat examiner? Certification: To Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No 28a. Date of Injury (Month, Day Year) uneral 27 Manner of Death 28b. Time of tnjury 28c. Injury at Work? 28d. Describe how injury occurred After ! 1X Naturel Attending 5 Pending investigation spital or Attendil nours after death. neral Director: A filled in by the fu death. 1 Yes 2 No 2 Accidant 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital
To the Funeral Completely filled edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and mannar stated. (Check only 29d. Data signed (Month, Day, Year) 29c. Licansa number 29b. Signature auti title of certifie SEPT. 14, 2000 O.C.M.E Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAFON OCKELO 111 Penn Street, Baltimore, Maryland 21201

**DHMH 16 Rev 6/95** 

State

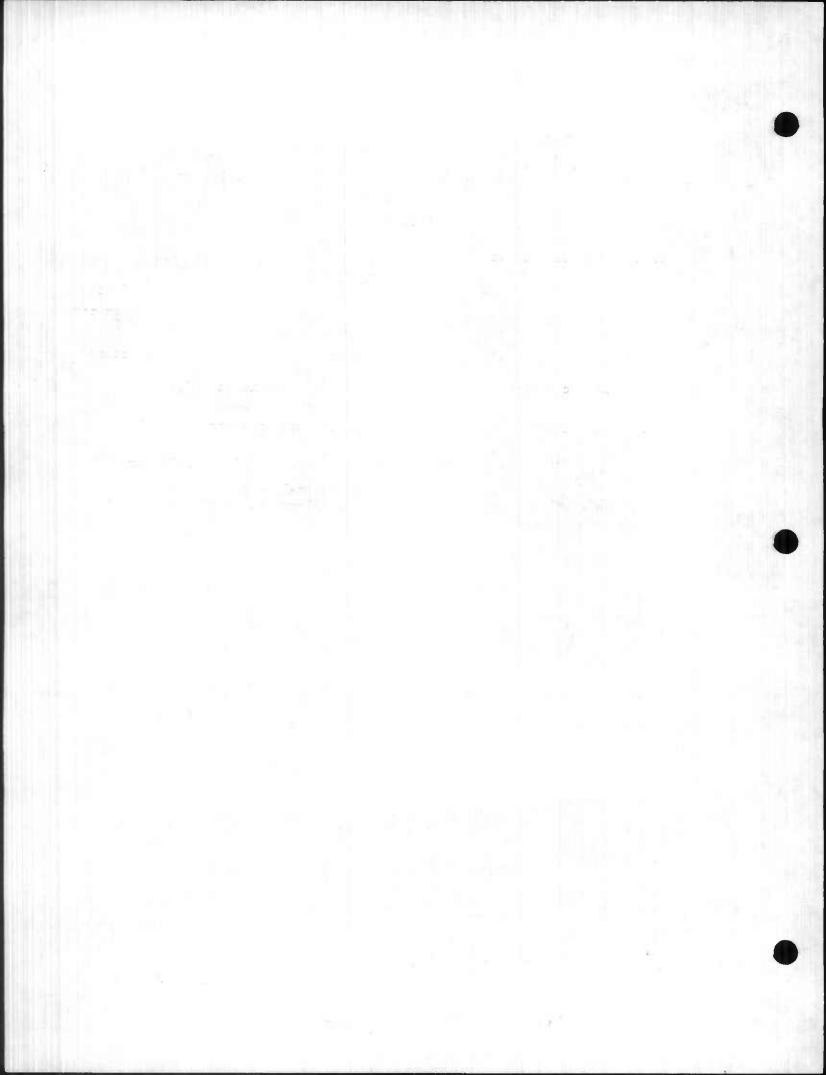
Registrar

31. Date filed (Month, Day, Year)

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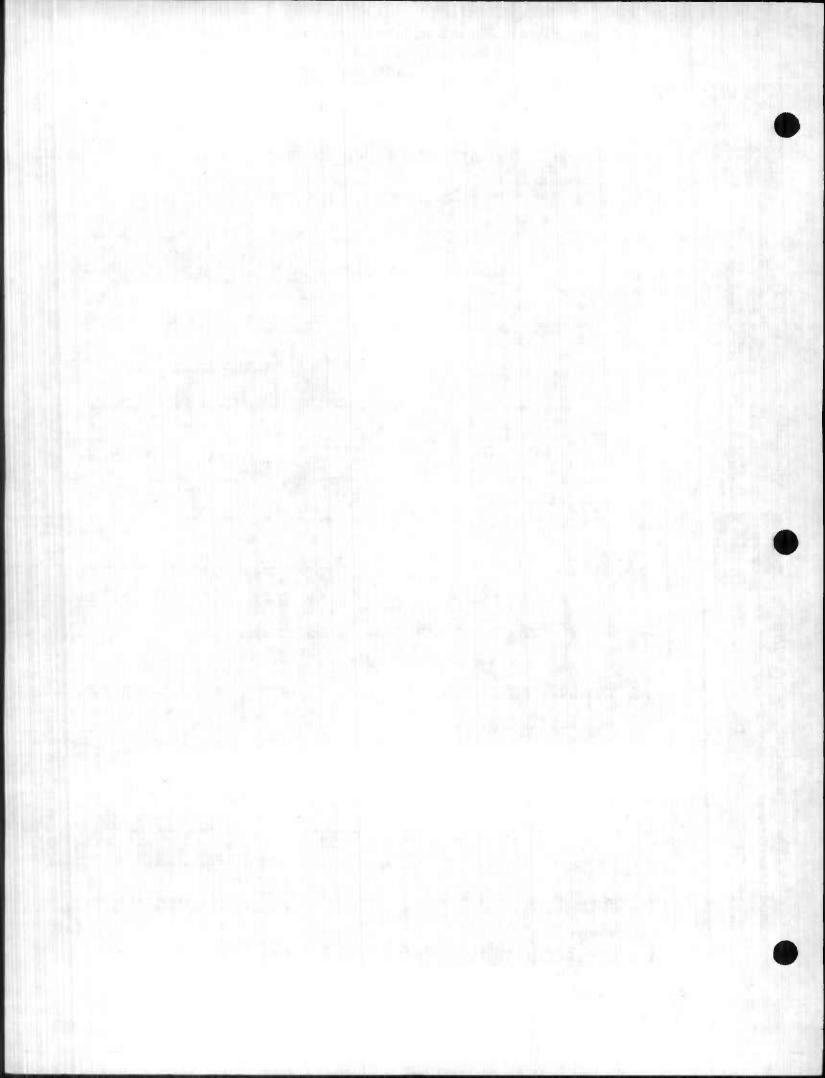
32. Registrar's Signature

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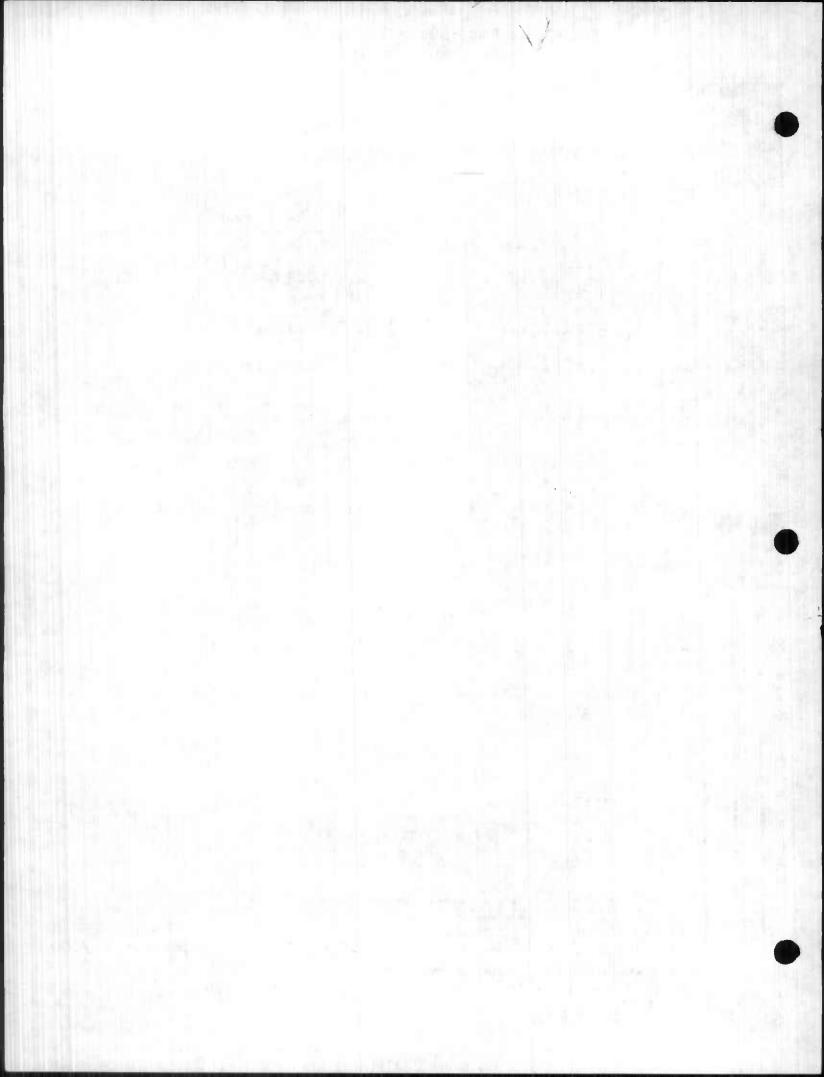
State of Maryland / Department of Health and Mental Hygiene

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neral ector	5. Social Security Number 215-07-0526	6. Sex 1  M 2  F	7. Age (In yrs. 83	Yrs.	Months De		Ain. (Month,	8,1917		(State or Foreig
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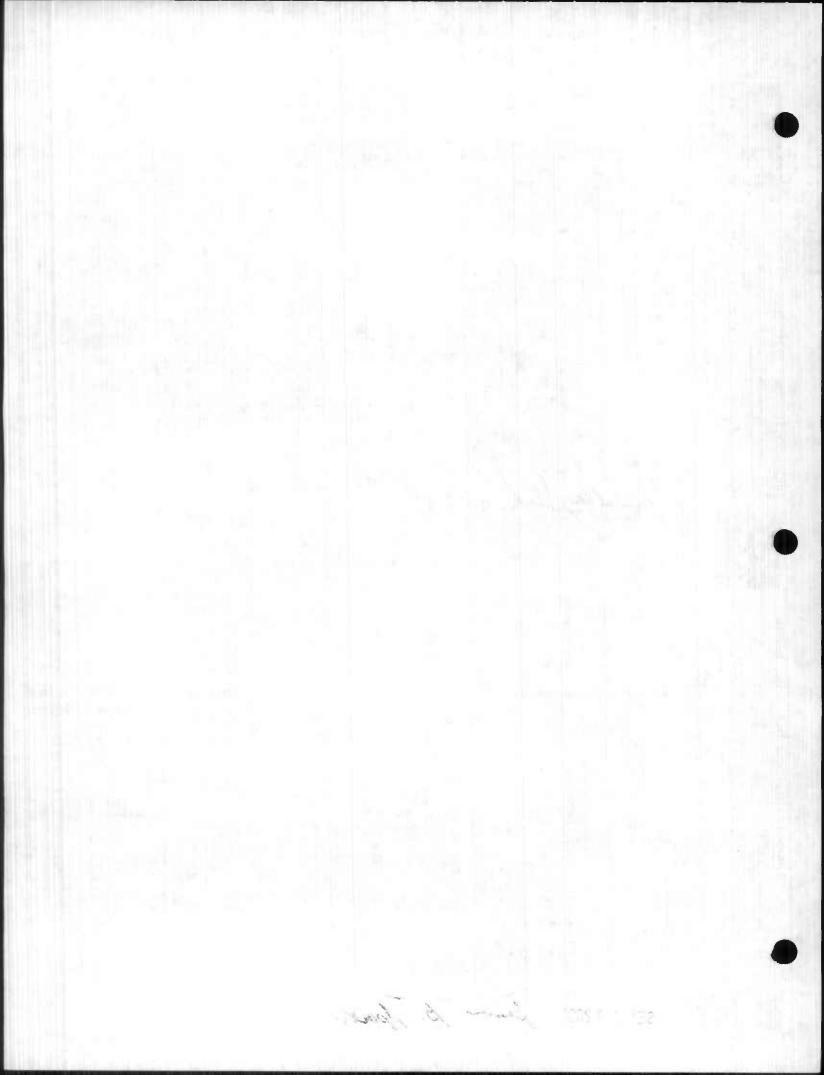
# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29463

Amended Ite	n#7 perFHG787 9/19/2000 EW	Certificate of Death	Reg. No.
Physician	Decedent's Name (First, Middle, Last)     ESTER	OKSMAN	2. Data of Death Month Day Year September 15, 200 11.34 Am
/Medical Examiner Funeral Director	219-38-4338	Age (In yrs. last birthday)  Age (In yrs. last birthday)  H Under 1 Year  Months Days Hours	n, or Location of Death 4c. County of Death
faryland show ad at	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or Location  BALTIMORE	10d. Inside City Limits 11/2 Yes 2 □ No
fiar deeth with the Maryland r frems 23s or 28s-f show that must be notified at Funeral Director	MD N/A  10e. Street and Number  4169 CREST HEIGHTS ROAD	10f. Zip Code 21208	10g. Citizan of What Country? USA
urs after br., or the Exercise by Fu	11. Marital Status  1 Never Married Ma	2 No 1 Yes 2 No Specify:	in? (Specify Yas or No- Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: WHITE
within 72 ane. than "ner the lic	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1	16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)  SEAMSTRESS	of working  16b. Kind of Business/Industry  GARMENT
d 2 should be filed th and Mental Hygin 7 is marked other traumatic event, II	17. Fathar's Name (First, Middla, Last) SHMUEL	OKSMAN 18. Mother RIVA	's Name (First, Middle, Maiden Sumama) (UNOBTAINABLE)
C TO N N	19a. Informant's Name/Relationship (Type, Print) ABRAHAM LORBER/HUSBAND		ror Rural Route Number, City or Town, State, Zip Code) ROAD BALTIMORE, MD. 21208
bernit. Pages 1 and Department of Health Important: if Itam 27 Inty Injury or other th	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from 5 4 Donation 5 Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place)  ARLINGTON—CHIZUK AMUNO	Date 20c. Location - City or Town, State 9/17/00 BALTIMORE, MD.
permit. Page Department of Important: if any injury or phos.	21. Signature of Funeral Service Licensee	22. Name and Address of Facility  8900 REISTERSTOW  sused the death. Do not enter the mode of dying, such as citch line.	SOL LEVINSON & BROS INC
Medical Examiner  fedical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):  Dua to (or as a consequence of):	
- UF 40	d		
hat the detached	Part II. Other algoriticant conditions contributing to de Rheumatoi d	ath but not resulting in the underlying cause given in Part I.  Arthritis	23b. Did tobacco use contributs to the cause of death?  1  Yss 2 No 3 Probably 4 Unknown
requir			24a. Was an autopsy performed?  24b. Were sutopsy findings available prior to completion of causa of death?
sician: The law requires to certificate has been signs lirector, page 2 should be	25. Was case referred to medical	26. Place	1 Yes 2 No 1 Yes 2 No
this ald	27. Manner of Death 1 Departural 5 Pending (Monte) 2 Accidant Investigation		
No Hospital or Attending P n 24 hours after death. No Funeral Director: After t pletely filled in by the funeral edical Certification:	4   Homicide buildir	of Injury - At home, farm, atreet, factory, office g, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral Medical Certification	(Check only one) 2 Medical Examiner: On the based mann	er stated.  29c. License number	a occurred at the time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
	30. Nama and address of person who completed cause	of death (Item 23a) (Type, Print)	September 15, 2000 kere Ave, Baltimore, MD 2021
State	Any M. Dvorcek, DO	2401 West Belved	kere Ave, Baltimure, mp 2021



State of Maryland / Department of Health and Mental Hygiene 00 29464

				Cer	uncai	e ui	Dealli			Reg. No.		
1. Decedent's N cian lical	Lucy H. O'Roark									oth Day Sep 14, 200	Year 0	3. Time of Death 9:15 a.m.
	e (If not institution,	give street and nu Charlestown		er			4b. City, To		cation of Deetl	4c. County		nore City
5. Social Securi		6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs.		If Unde Montha	Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Apr	th y, Year) 7, 1906	9. Birthp Cour P	place (State or Foreigntry) ennsylvania
Usuai Residenc												
10a. State	10b. County		10c. C	ity, Town or Lo	cation						1	10d. Inside City Limit
Marylar	nd	Baltimore				(	Catonsv	ille				t 🗆 Yes 2 🗆 N
10e. Street and	Number				10f. Zip	Code				10g. Citizen of	What Cour	ntry?
Charle	town Care Ce	enter					21	228			U.S	.A.
1 t . Marital State	ıs	12. Was Dec	edent Ever in U	J,S. 13. V	Vas Dece	dent of	Hispanic Or	gin? (Spe	ecify Yes or No Rican, etc.)	- 14. Red		can Indisn,
1 Never N	larried 2 Marrie		2 No						rican, etc.)		ck, White,	
3 Widowe	d 4 Divorced	If Yes, Gi			☐ Yes	2 LM0	Specify:			Specif	y:	White
	15. Decedent's			16a. Deced	ent's Usu	al Occu	pation			16b. Kind of B	uainess/In	dustry
	pecify only highest econdary (0-12)	College (		life. L	OO NOT u	se retire	during mos	r or work	ng		Mill	Work
	unk.	College (	1-401 3+)				Sewer				141111	VVOIK
17. Father's Na	ne (First, Middle, L.	ast)`					18. Mothe	er's Name	(First, Middle	Maiden Sumar	ne)	
	Jo	ohn Hoover								Effie Murr	у	
19a. Informant'	Name/Relationshi	io (Type, Print)		19b. Mailin	a Addres	s (Stree	t and Numb	er or Run	al Route Numb	er, City or Town	State, Zin	Code)
		Funeral Hom	ne.							ester, Virg		
20a. Method of		- directar rion		Place of Dispo	sition (Na	me of			Date	20c. Location	- City or To	own. State
1 🗆 Buriel	2 Cremation			cemetery, cren	natory or	other pla			09/18/00			loah, VA
	on 5 Other (Spe						orial Par	-	00/10/00		Tictianic	Joan, VA
21. Signature o	icense	- MOOS.			Jones	ess of Facili S Funera S. Pleasa	I Hom		Vinchester	. Viraini	ia 22601	
23a/Partt. Ent	er the disease, or o	complications that			er the mod	de of dy	ing, such as	cardiac o	or respiratory a	rrest,		Approximete Interval Between
/												Onset and Death
Immediate Cau	se (Final		C	1.00	Dan	01	1) -	EAS	_			YEARS
resulting in dea	ih)	a		or as a conseq	uence of)	. = 12	1115	6747	E		1	1 GAROS
34.57												
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Cause (Diseese that initiated ev	or injury	C	Due to (	or as a consequ	uence of):							
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Part II. Other si	nificant condition	e contributing to d	leath but not re	sulting in the ur	nderiving	cause q	iven in Part	1.	23b. Dld	tobacco use co	ontribute t	o the cause of deat
												bably 45 Unkno
									24a. Was	an autopsy		ere autopsy findings
			11000						perto	ormed?	CC	vailable prior to empletion of cause death?
										- 57		
										Yes 2 Noto	1	☐ Yas 2☐ No
examiner?	eferred to medical	Hospital:				100		e of Deet	h (Check only	one)		
1 Yes	No	10		ER/Outpatien		UA		-		dence 6 Ot		fy)
27. Manner of D	eath 5 Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time of Injury		28c. Inju Wo	ry at ork?		28d. Describe	how injury occu	rred	
2 Accider	investige	ation			М	1[	Yes 2					
3 ☐ Suicide 4 ☐ Homici	determin	200. Place	a of Injury - At h	nome, farm, str	eet, factor	y, office				Street and Num wn, State)	ber or Rur	al Routa Number,
29a. Certifier (Check only one)		Physician: To the xaminer: On the b										
	and title of certifier	W.1.0 1.1101	/		29	c. Licen	se number		-	29d. Date signe	ed (Month.	Day, Year)
1	177	1. 1	1					10		-		4.1
//		0,10	ma			DY	147	18		EPTEN	1 BER	14, 2000
	ddress of person w	,	se of death (Ite	m 23a) (Type,	Print)							
	ELON J. N	ARROT	7111	MAIRE	V C	HOIC	ELA	NE	CATON	SVILLE	,00	21228
	fonth, Day, Year)	12.1	legistrar's Sign	lature	1							
	P 1 9 2000	1 Sen	me	B. 1	loon	61						



#### Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9465 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth ANOR ORT 309.M. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Name (If not institution, give street and number) a IMORE TON If Under 1 Yeer 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 2444.466 10 M 20 F Days Usual Residence of Decedent 10b. Count 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore DOYes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1300 S. Elwood Avenue U.S.A. 21224 14. Raca - American Indien. Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐No Specify: Specify: White 3€ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Romaine Elburn Ella Elburn 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1613 Honeysuckle Dr. Forest Hill, Maryland 21050 James O. Porter Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 9/15/00 Baltimore, Maryland 4 ☐ Donelion 5 ☐ Other (Specify) Oaklawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 23a. Part1. Enter the disease, or compliant ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 24 lus GASTROINTESTINAL Due to (or es e consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as e consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 21 No 3 Probably 4 Unknown DIABETES RELLITUS 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 20 No 1 Yes 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Department of Important: If Its any injury or o 0

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

p

Completed

Be

MD

**Funeral** 

**Director** 

"natural", or items 23s or 28s-f show

other traumatic event, the Medical Examiner must be notified at

I Hygiene.

Mental

Pages 1 and 2 should be if Health and Menta Itam 27 is marked

the Manyland

filed within 72 hours after death

Baitimore, Maryland 21215-0020

Box 68760.

Division of Vitai Records, P.O.

attending physician and for use as the burial-tran signed by page 2 should has certificata this

The law requires that the death certificate be axecuted

Physician/Medical Examiner py Completed Be 10

or Attanding Physician: s after death. Certification: filled in by within 24 hours a Hospital edical

State Registrar

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) Q. VERGARA - SOARES

29b. Signature and title of contiller

25. Wes case referred to medical

5 Pending investigation

124 Dear

Could not be

1□Yes 2 No

27. Manner of Death 1 Netural

2 Accident

3 Suicide

29a. Certifier (Check only

4 Homlcide

1300 S. ELLWOOD AVENUE

28c. tnjury et Work?

11 Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29c. License number

D16619

1 Yes 2 No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Sept. 13, 2000

BALTIMORE, MO. 21224

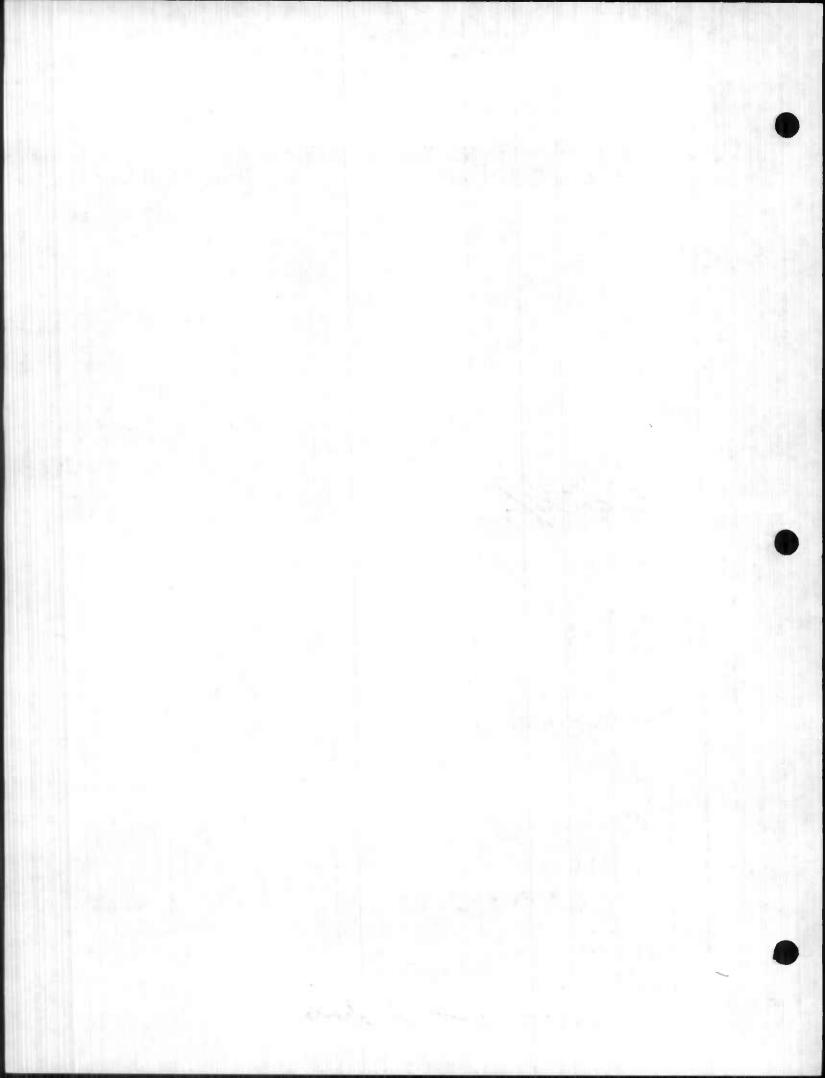
31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 1 9 2000

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

110



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Eleanor Mae Pierce 2000 September 17 9:13 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mariner Health of Forest Hill Forest Hill If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1 M 2 XF Months Days Yrs. 191-07-7253 86 12, 1914 Pennsylvania Usual Residence of Deceden 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 Forest Valley Drive #204 21050 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☑ Widowed 4 □ Divorced 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Federal Government 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) H. B. Rhines Christine Donaldson 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha P. Hill/Daughter P.O.Box 68, 16402 Falls Rd. Monkton, MD 2111 ce of Disposition (Name of Date 20c. Location City or Town, State 21111 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 9-18-00 Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Euneral Service License Thomas Gregor Dogo 299 Frederick Road Baltimore, 21228 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onsel and Daath Immediate Cause (Final disease or condition resulting in death) den Due to (or as a consequen de Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? 1 Yes 1 ☐ Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred

Examiner Examiner The law requires that the death certificeta be executed physician the burie Box 68760. USe P.O. Records, Division of Vital or Attending Physician: this After To the Hospital or Attendir within 24 hours effer death. To the Funeral Director: A

filled in by

completely

State Registrar

Physician/Medical à Completed 8 Medical Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f

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Barra 23a

other than "ratural", or her vent, the Medical Examinar. filed within 72 hours after

. Pages 1 and 2 should be fill then to Health and Mental Hants (Mental Hants IT is marked oth fury or other traumatic even

Department of Important: If any injury or

**Physician** 

/Medical

Baltimore, Maryland 21215-0020

Directo

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29a. Certifier

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 Pending investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

281. Location (Street and Number or Rurel Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier

29c. License number

032277

29d. Date signed (Month, Day, Year)

September 18, 2000

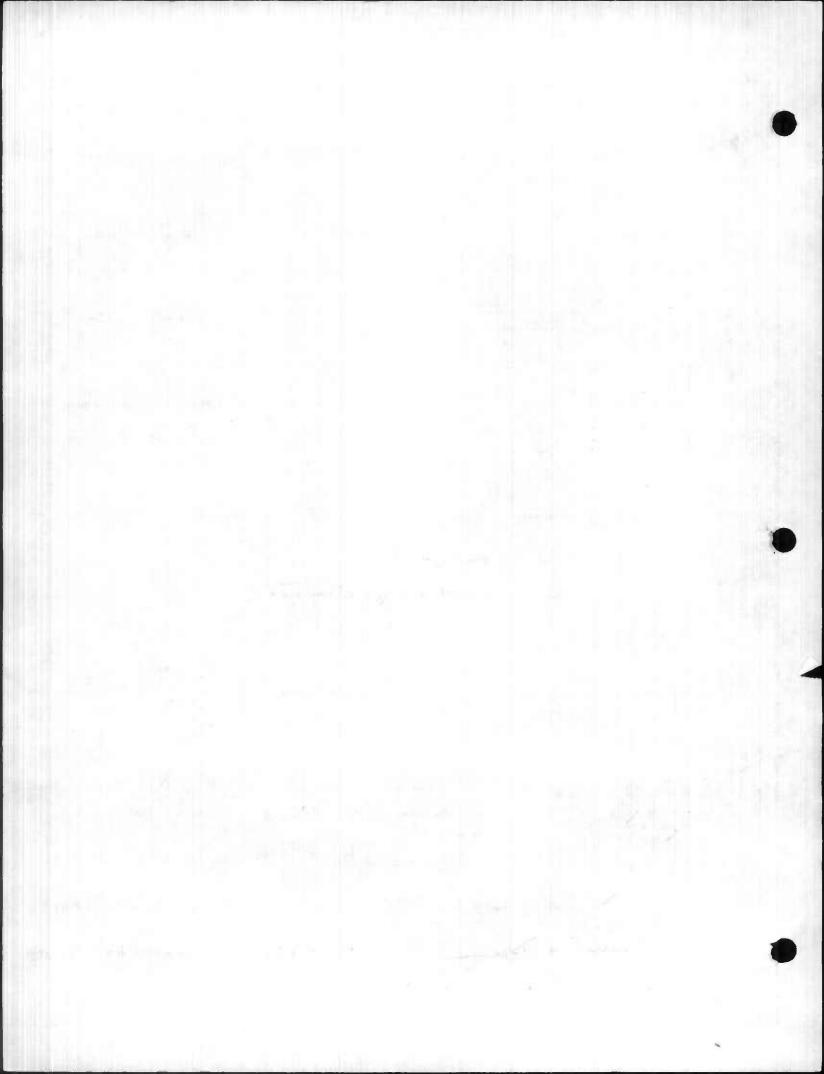
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

awar S 31. Date filed (Month, Day, Year)

1 9 2000

615 32. Registrar'a Signature MacPha.



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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	1	4		0	

Physician /Medical	Barbara Anne Pringle									Month Day Year March 16,2000 9:00 A.M.						
Examiner	4a Facility Neme (If not institution, give street and number)  4b. City, Town, or									own, or L	ocation of	Death	4c. County			
161 L	Prince George's Hospital								Cheverly				Prince George le			
Maryland 21215-0020  and 2 should be filed within 72 hours after death with the Maryland of the antide or other than 'natural', or thems 23a or 28a-1 show the traumatic event, are Medical Exercises must be notified as a result of the Completed by Funeral Director	5. Social Security Number  460-74-7737  Usual Residence of Decedent			7. Age (In yrs. last birthday)  7. Age (In yrs. last birthday)  Months  Yrs.			er 1 Year S Days	s Hours Min. (Month,			n, Day, 1	9. Birthplece (State or For Country) 1947 Houston, TX.				
	10a. State	10b. County	,	10c. City, Town or Location								_	10d. Inside Cit			
	MD				orge's C1			lînton						N☐Yas 2[		
	10e. Street and N 13007 J∈		reet,	t, West				Zip Code					10g. Citizen of Whet Country? U. S. A.			
	3 ☐ Widowed	s erried 2 Men 1 4 Divorced	ried 1	12. Was Decedent Ever in U,S. Armed Forces?  1 Yes 2 No If Yes, Give Yeer or Detes:			13. Wes Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto F					ify Yes or No- can, etc.)  14. Rece - American Indian, Black, White, etc.  Specify: Black			c.	
	(Sp	15. Deceden	st grade con	mpleted)	16a. Dece (Give life.	16a. Decedent's Usuel Occupation (Give kind of work done during most of work life. DO NOT use retired)					16b. Kind of Business			stry		
	Elementery/Se	econdary (0-12)	5	Cotlege (1-4or		Microbiologist					U	U. S. Govt.				
	17. Father's Nem	Pringle							18. Mother's Neme (First, Middle Lucy Reed Pring							
											furel Route Number, City or Town, State, Zip Code)					
Baltimore, semil. Pages 1 a separament of Hec monstraint if them my injury or othe siste.	20a. Method of D	Dorothy Greer - Friend    1350 Legate Rd., NW, Washington, DC, 20012   20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, cremetory or other place)   20c. Location - City or Town, State   2 Cremetory, cremetory or other place)   2 Cremetory, cremetory or other place)   2 Cremetory, cremetory or other place)   3/23/00   4 Constant   3/23/00														
Baltim permanent myoertant eny injury ence	21. Signayungki	whole	Tres	P	4 1 2 4 2								DC, 20		l nc .	
Physician /Medical Examiner	3831 Georgia Ave. No.   1882   1883											Č	ntervel Between Onset end Death			
s, P.O. Box 68760, as that the death certificate be associed gned by the attending physician and be detached for use as the burial-transit by Physician/Medical Examiner																
		d.														
	Pert II. Other sign	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.  Congestive Heart Disease										23b. Did tobacco use contributs to the cause of death?  1 Yes 2 No 3 Probably 4 🛱 Unknown				
cord v require been si should											240.	24e. Wes an eutopsy performed?  24b. Were sutopsy findings swellable prior to completion of cause of death?			able prior to pletion of cause	
Division of Vital Record after death. Director: After this certificate has been s in by the funeral director, page 2 should ertification: To Be Completed													1 X Yes 2 No 1 Yes 2			
	25. Was case ref	ferred to medica	edicat 26. Ptece of De								ith (Check	only one	)			
		Ŋ No	Hospi	Hospitel: 1   the triangle of							ome 5 Residence 6 Other (Specify)					
		5 Pending investigation 6 Could not be		28e. Dete of Injury (Month, Day Year)  28b. Time of tnjury  M  28c. injury at Work?  1  Yes 2  No						rred						
	3 Suicide 4 Homicid		not be nined 28	28e. Plece of injury - At home, farm, street, fectory, office building, etc. (Specify)							281. Location (Street and Number or Rural Route Number, City or Town, Stete)					

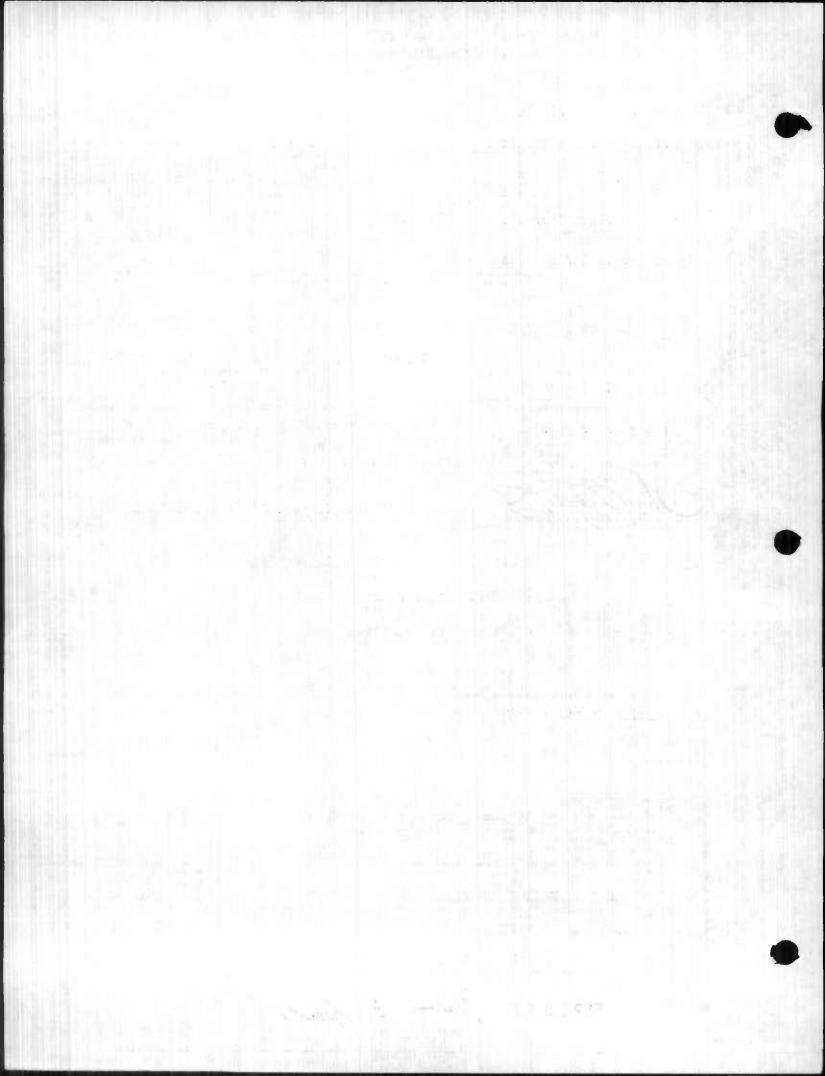
State Registrar 29e. Certifier (Check only one)

29b. Signature and title of certifier

DHMH 16 Rev 6/95

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated.



Please Type or Print in Biack Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#23A PER MD. G787 9-19-2000 JAB 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** POWELL ROSA SEPTEMBER 21:30 7,2000 /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) (Month, Day, Year) 11-24-1952 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 X 47 Yrs. 229-80-0646 Va Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show 1 ☐ Yes 2 ☑ No Directo Md Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or flams 23s or than "natural", or hems 23s or the Medical Examiner must be. 21045 USA 8860 Tamar Drive Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritel Stetus filed within 72 hours after 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Clerk Amoco Store 10th grade N/A permit. Pages 1 and 2 should be file.
Department of Healths and Mental Hyp,
important if flew 27 is marke.
Stick. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Hallie Pannell Charlie Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) George Easley- Son Avenue Baltimore, Md 710 McCabe 20a. Method of Disposition

\*\*LABurial 2 | Cremation 3 | Removel from Stete 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Organ Chapel Church Cem 9-14-00 Campbell Co. Va 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service Licensee March F/H West Jan 4300 Wabash Avenue Baltimore, Md 21215 Enter the pisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or hour failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician BRAIN VESSEL ANEURSYM Immediate Cause (Final disease or condition resulting in deeth) /Medical 10 hours Examiner Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use es the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 12 No 1 ☐ Yes 22 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home Certification: To 1 MInpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

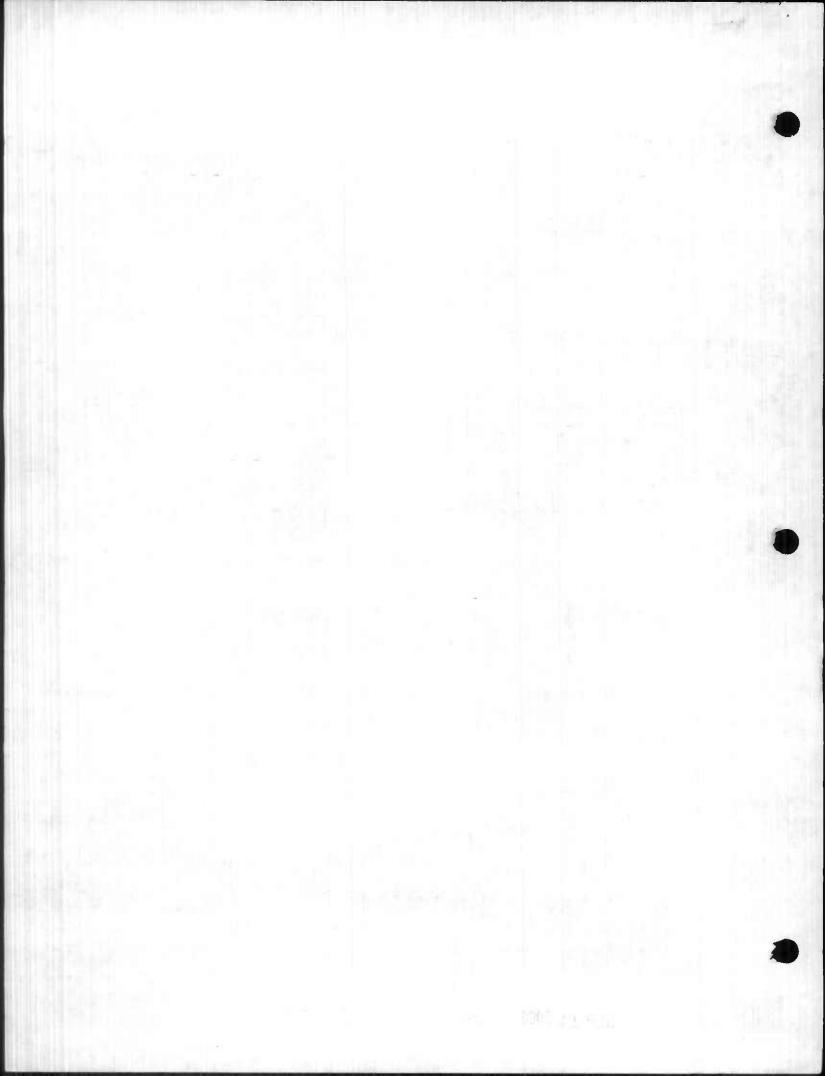
To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital 156 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted. edical 29a. Certifier (Check only one) 29c. License number 29b. Signeture end title of certifier 29d. Date signed (Month, Day, Year) 21D RES\_000 September 17, 2000

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature 9 2000

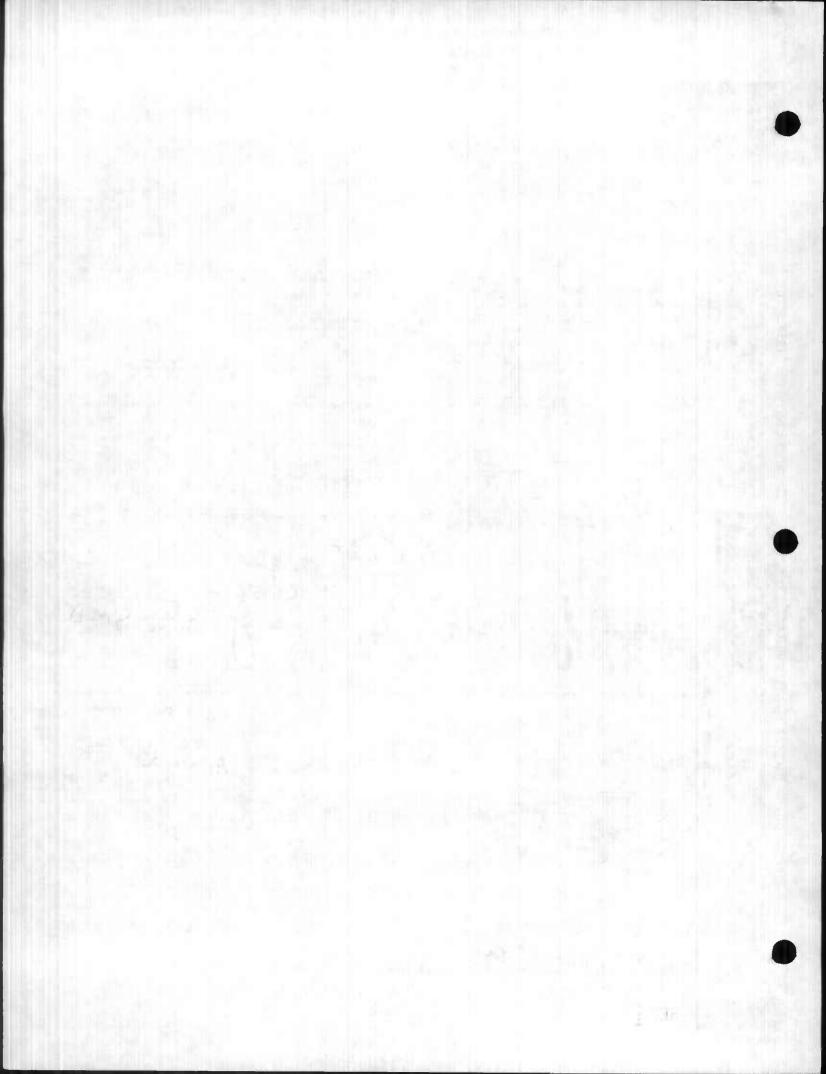
30. Neme and address of parson who completed cause of death (item 23a) (Type, Print)

MICHEL TORBEY, Johns Hopkins Hospital, 600 North wolfe street, Baltimore HD 21259



State of Maryland / Department of Health and Mental Hygiene 00 29469

		Certificate of Death	Reg. No.
Dhusisian	1. Decedent's Name (First, Middle, Last)	0-	2. Date of Deeth Month Day Year
Physician /Medical	LED	TOKEMSKI	- SKIDTEMIKUL 2000 2:30 pm
Examiner uneral	MAN SOLE OF	MEAL CENTRAL BALFT.  It Under 1 Year It Under 24 Hr.  Mindths Devs Hours Min	
rector	Usual Residence of Decedent	Yrs. Situation City, Town or Location	
a notified at Director		Baltimore	10d. Inside City Limits 1) Yes 2 □ No
. 44	10e. Street and Number 1239 Broening Highway	10f. Zip Code 21224	10g. Citizen ot What Country? USA
Examiner must	11. Maritel Stetus  1 Never Merried 2 Merried  1 Never Merried 2 Merried  3 Widowed 4 Divorced  12. Wes Decedent Ever in Armed Forces?  12. Yes Decedent Ever in Armed Forces?  12. Yes Decedent Ever in Armed Forces?  13. Yes 2 No It Yes, Give Year or Detes:	n U,S.  13. Was Decedent of Hispanic Origin? (: If Yes, specify Cuben, Mexican, Pue)  1 □ Yes ZEI No Specify:	Specify Yes or No- rto Ricen, etc.)  14. Raca - American Indien, Bieck, White, etc.  Specify: White
r, the Medical	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usuel Occupation (Give kind of work done during most of woilife. DO NOT use retired)	16b. Kind of Business/Industry
dwo	Elementery/Secondery (0-12) Cotlege (1-4or 5+)	Molder	Steel
To Be C	John Poremski		me(First, Middle, Meiden Sumeme) a Zuchowska
ar trauma	19a. Intormant's Neme/Reletionship (Type, Print) Lucinda Poremski wife		hway Balto. Md. 21224
ury or oth	1 X Burial 2 Crameting 3 Demoval from State	p. Place of Disposition (Name of cametery, cremetory or other place) arrison Forrest V. A	Sept. 18 Owings Mills
any in	21 Signature of Fundal Service Licenses	22. Name end Address of Fecility Connelly Funera 7110 Sollers Po	l Home Of Dundalk int Rd. 21222
1.1	23a. Part1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line.	eeth. Do not enter the mode of dying, such as cardia	Approximeta intervat Between Onset end Death
cian lical iner	Immediate Cause (Finel disease or condition resulting in death)	real HEMATOMA	9 DAYS
sit liner	b. Fax RAAA	RENCHYMIL HEMORUS	19 Jays
burial-transit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	o (or es a conseduence of):	ESCATION APPROVED BY MEDICAL EXAMINER
ding physician and ise as the burial-tra	that initieted events resulting in death) Last  Due to	o' (or as a consequence ot):	
ed by the attendinded for use	Pert II. Other algnificant conditions contributing to death but not	resulting In the underlying ceuse given in Part I.	23b. Did tobacco usa contributa to the cause of death?
be detach by Phy			1 Yas 2 No 3 Probably 4 Unknown
2 should pieted			24a. Wes an eutopsy performed?  Approvided A
ertificate actor, pa Be Co	25. Was case referred to medical axaminer?	26. Plece of De	1 Yes 2 No 1 Yas 2 No
To E	Yas 2□ No Hospitel: 1 Hopatient 2		Home 5 ☐ Residenca 6 ☐ Other (Specify)
he funera	27. Menner of Death    Neturel   5   Pending   (Month, Dey Year Special Properties)   1   1   1   1   1   1   1   1   1	17 DO OM 11 Yes 212No	28d. Describe how injury occurred  FELL DOWN 354 FLPS
To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com	3 Suicide 6 Could not be determined 28e. Pleca of Injury - A building, etc. (Special Could not be determined)	at home, farm, street, factory, office	281. Location (Street and Number or Rural Route Number, City or Town, Stete)  1239 BLOKNING RIGHTAY MARY/AW)
Funer letely fill dical	29e. Certifier (Check only one)  Certifying Physician: To the best of my land the control of the best of my land the control one)	knowledge, deeth occurred et the tima, dete and pleo inetion end/or investigation, in my opinion, death occ	e, end due to the ceuse(s) and manner as stated.  urred et the time, date end plece, and due to the cause(s)
Comp	29b. Signature and title of certifier	29c, License number	29d. Date signed (Month, Dey, Year)
(	I mol cola	KR5-600	SKOTERES 12, 2000
1	30. Name and address of parson who completed cause of death (I	2 11	May (Au) 21274
State	31. Dete tited (Month, Dey, Year) 32. Registrer's Si	orfature of the control of the contr	MINNY (AM) - 122
Registrar	SEP 1 9 2000 Sever	sports	



State of Maryland / Department of Health and Mental Hygien

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e	00	-	4	4

CHRISTINE RODGERS Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** SEPT. 17, 2000 1405 PM Christine Rodgers /Medical Facility Name (If not institution, give street and number)
JOHNS HOPKINS HOSPITAL E.R. 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09-2.1-35 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (fn yrs. last birthday) **Funeral** Months Days Hours 1 M 2 F Yrs. 64 NC Director 213-34-5350 Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural', or flams 23a or 28a-f show 1 Ves 2 No Director MD NA Baltimore the Medical Examiner must be notifi-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1237 E. Lanvale Street 21202 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Saltimore, Maryland 21215-0020 À Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Elementary/Secondery (0-12) College (1-4or 5+) 8th Grade in home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 88 Pages 1 and 2 should be nent of Health and Mental int: If Item 27 is merked o 2 Willis Alston Mildred Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21202 19a. Informant's Name/Relationship (Type, Print) Franchesca 1237 E. Lanvale Street Baltimore, Maryland Rodgers 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify) Cedar Hill Cemetery 09-22-2000 Anne Arundel Co 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Maryland 21202 ladip WM.C.March FH 1101 E. North Avenue aner 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Arteriosclerotic Cardiovascular Disease disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examine The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) attending physician for use as the burla 68760 that initiated events resulting in death) Last Due to (or as e consequence of) Box P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? signed by I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown RENAL FAILURE Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy page 2 should inspection certificate hes 1 ☐ Yes 2 🖾 No 1 Tyes 2 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred tnjury at Work? Certification: Affer or Attending 5 Pending investigation ours after death. eral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C completely filled the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

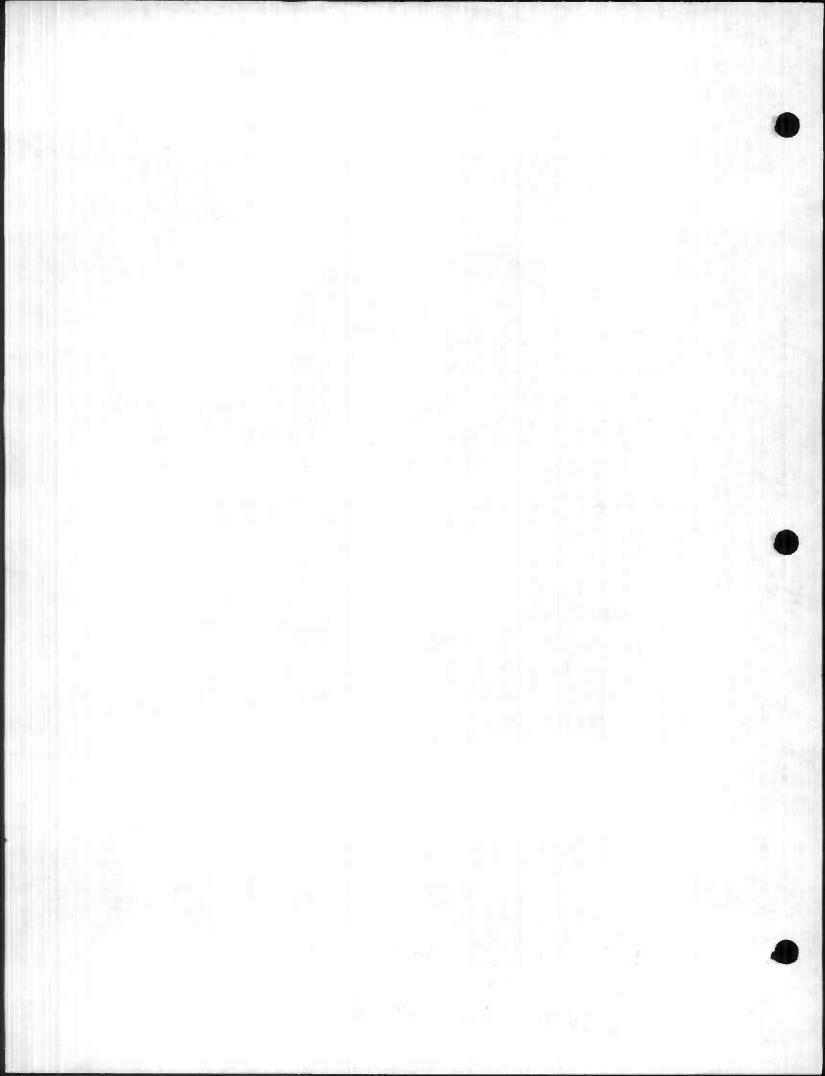
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E SEPT. 18, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) estance 111 Penn Street, Baltimore, Maryland 21201 OSE

State Registrar

SEP 1 9 2000 **DHMH 16 Rev 6/95** 

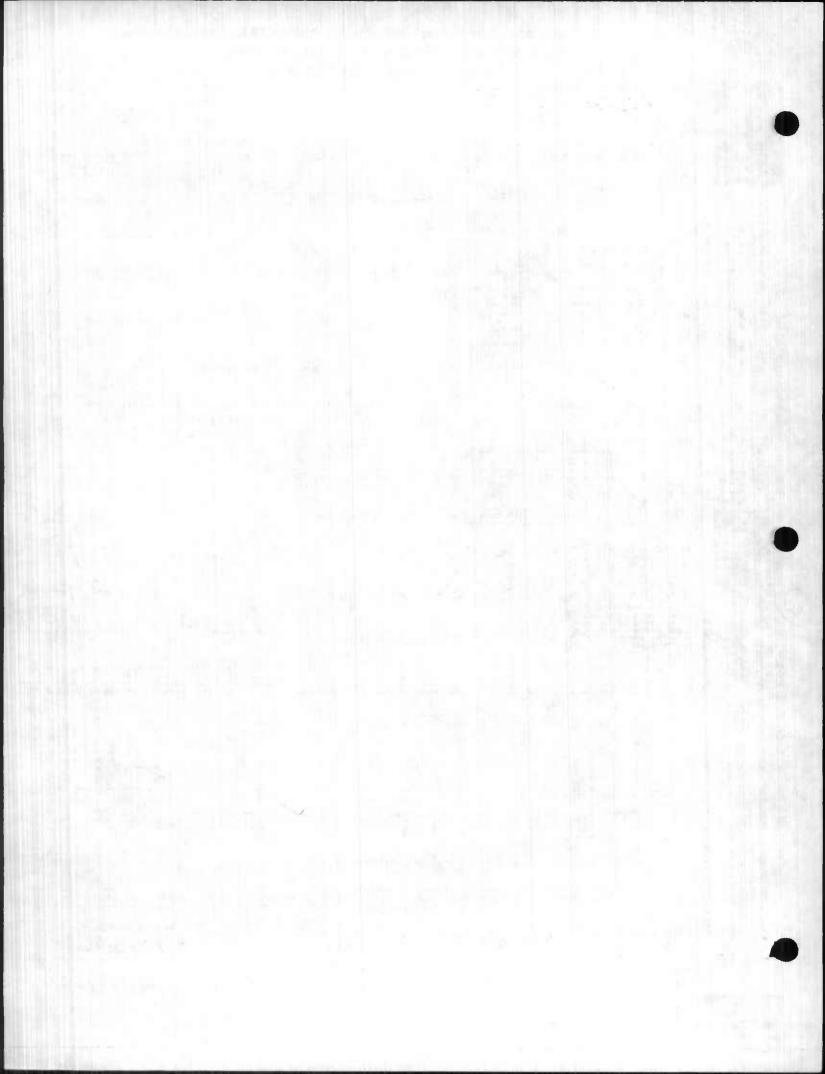
31. Date from Month, Day, Year)

32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene 0 29471

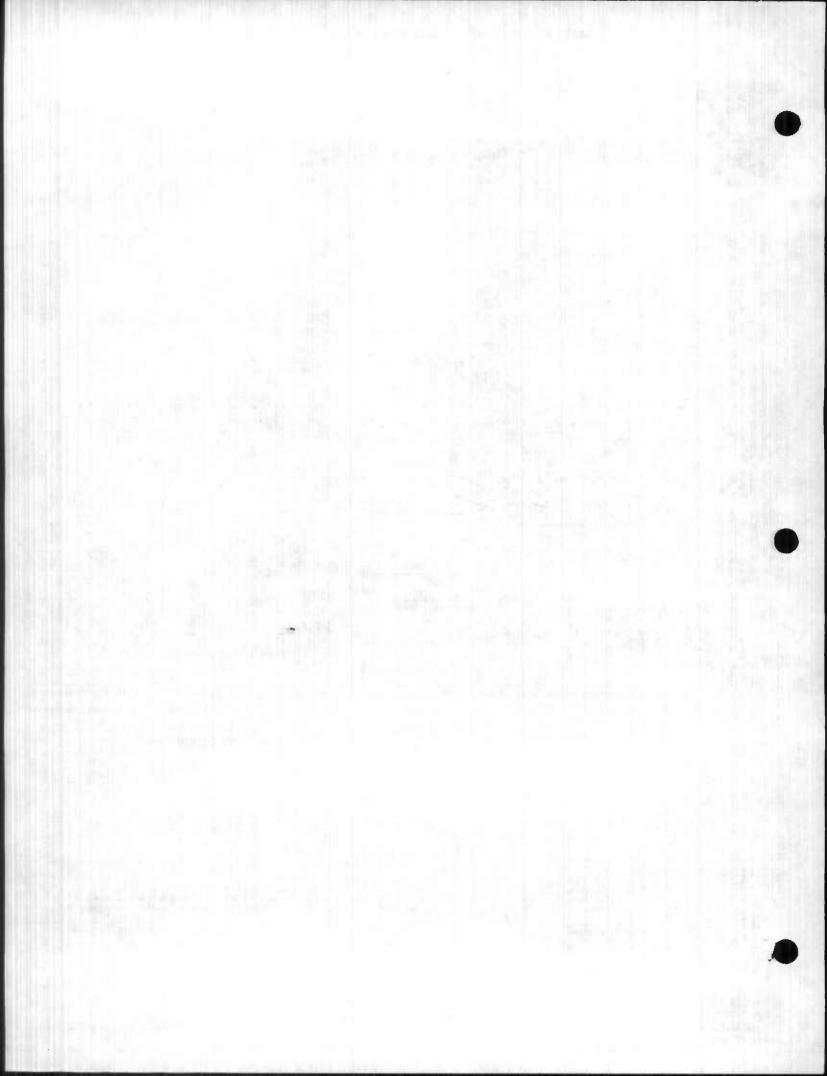
		in the second second		Cert	ificate o	f Death		leg. No.	47411
	Physician		T RHU	DY			2. Date of Dea Month	th Day Yes	
	/Medical Examiner	de Casille, Name /// and Institution who	a street and number)			4b. City, Town, o	or Location of Death	4c. County of Do	
	LAdimirei	Johns Hopkin	s Bayview Me	dical	Cente	r Bal	ltimore	n/a	
	Funeral Director	5. Social Security Number 6. S	-	ast birthday)		r If Under 24 H		14,1913	Birthplace (Stete or Foreign Country) N.C.
	de ga	10a. State 10b. County		, Town or Loca					10d. Inside City Limits
	or 28s-f sh be notified.	Md. Balti	more D	undall					1 ☐ Yas 2X No
					10f. Zip Code 2122	22		USA	
21215-0020	ours after death valle, or fleme 23 Examiner must 3 by Funeral 3 by Funeral	3∰Vidowed 4 □ Divorced	12. Was Decedent Ever In U. Armed Forces?  1 Yes 2 No If Yas, Give Year or Dates:	If Y	es Decedent of res, specify Cu ☐ Yes 2 [X] N	ıban, Mexican, Pu	(Specify Yes or No- arto Rican, etc.)	14. Race - Ai Black, W Specify:	merican Indian, Thite, atc. White
15-6	ed within 72 ho or than "nature", the Medical. Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Deceder	nt's Usual Occ	upation le during most of w red)	vorking	16b. Kind of Busine	ss/Industry
212	twithin the Man	Elementary/Secondary (0-12) 12 yrs.	Coilege (1-4or 5+)		usewif			Hom	ne
P	d other				E-1-17	18. Mother's N	lame (First, Middle,	Maiden Sumema)	
ylar	Menta Menta	Charles W. J	ohnson			Mart	ha Leela	h Cheaty	vood
, Mar	and 2 sho alth and 27 is me or traum	19a. Informant's Neme/Ralationship ( Phillip Rhud						r, City or Town, Stete Md. 212	
altimore	Pages 1. ment of He ant. If Item ury or oth	20a. Method of Disposition  12 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	ace of Disposite o	tory or other p	lece)	Sept. 18	20c. Location - City Balti	
Balt	Depart Depart Import any in	21. Signatura of Fuberal Service Logo	9	Con	nnelly	ress of Facility Funera Lers Po		Of Dunda 21222	ılk
Co.		23a, Part1. Enfor the disease, or com- shock, or heert failure. List only	cations that caused the death	. Do not enter	the mode of d	ying, such es card	iec or respiretory ar	rest,	Approximate Interval Between
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	arterio	Sclero	the -	Hear	T Dise	ase	Onset and Deeth
	<u> </u>		Que to (or	as a conseque	ence of):			-	7 7 14
))	n and lettransit	Sequentially list conditions	b. Due to for	as a conseque	ence of):			1	12 year
68760,	e be executed risitian and buriel-transit cal Examin	Cause (Disease or Injury	с.	as a conseque					
Box 68	Aedi	resulting in death) Last	d	as a conseque	srica Oi).				
m	death ce attendii d for use	Part II. Other algnificant conditions of	ontributing to death but not resu	Iting in the und	lariving cause	niven in Part I	23b Did t	obacco usa contrib	ute to the cause of death?
, P.O	that the death ce ed by the attendin deteched for use y Physician/I							/as 2□ No 3□	
of Vitai Records,	The law requires that the disable has been signed by the page 2 should be detected.						24a. Was perfor	an eutopsy med?	b. Were autopsy findings available prior to completion of cause of death?
Œ	The la						101	es 2 No	1 ☐ Yes 2 ☐ No
/ita	ysician: The sis certificate director, pag			,			Death (Check only o	ne)	
=	hya his hya	1 □ Yas 2 Ū No		ER/Outpatient	3LI DUA			ence 8 Other (5	ipecify)
ion	Attending P or death.  Petter: After the funering the function the function the funering the function the funering the funering the funering the funering the function the funering the function the function the function the function the fun	27. Manne of Death  1 2 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of injury	28c. In W	jury at /ork? □ Yes 2 □ No	28d. Describe h	ow injury occurred	
Division	or Attendant of the control of the c		28e. Placa of Injury - At ho building, etc. (Specify	me, farm, strea )	t, factory, offic	e	28f. Location (S City or Tow		r Rurel Route Number,
	Hospi 24 hou Funer Hely fill dicai		yalcian: To the best of my know hiner: On the basis of examinat and menner steted.	vledge, death o ion and/or inve	occurred at the stigation, in my	fime, date end pla y opinion, death oc	ce, end due to the c courred at the time,	cause(s) and manner date and place, and o	ras stated. due to the ceusa(s)
	within To the comple		0 17.			nse number		29d. Date signed (M	
	10	) m	O A VAN		00	11150		9/15/	2000
	Ch	30. Name and address of person who	completed cause of death (Item	23a) (Type, Pr	rint) S F	- L(won	PAUER	1/00/10	21224
	State	31. Date filed (Month, Dey, Year)	32. Registrar's Signal	ure	٠, ٠	2011009	1,00	, CIOMI)	01204
	Desiration	SED 4 n 2000	ma line 1		. 5 .				



State of Maryland / Department of Health and Mental Hygiene

	- 4						
ne	0	0	2	9	L	7	5
No.			- Coppens			-8	6.

			Ce	rtificate of	Death		Reg. No.	0 4	2316	
LIL.	1. Decedent's Name (First, Middle,	Last)				2. Date of D	eath	Vans	3. Tima of Death	
Physician /Medical	Mary Alma Sheck	ells				Septem	ber 14,2	000	11:15 AM	
Examiner	4a Facility Name (If not institution, g Heritage Nursin				4b. City, Town Balti	n, or Location of Dea More		of Death imore		
Funeral Director	213-28-5135		(In yrs. last birthday, 86 Yrs.	Months Day		Min. 8. Date of Bi	nth 1913	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent  10a. Stete 10b. County		10c. City, Town or L	ncation				10	d. Inside City Limits	
ad at	MD N/	A	Baltimor						1. Yes 2 No	
be notified Director	10e. Street and Number			10f, Zip Code			10g. Citizen of V	What Countr	A	
	4709 Greenhill A	venue	State	,	206		U.S.			
Examiner must by Funeral	11. Marital Status  1 Never Merried 2 Married  3 Widowed 4 Divorced	12. Wes Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Yeer or Detes:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No	ban, Mexican, i	n? (Specify Yes or N Puerto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.  Specify: White			
dicat	15. Decedent's (Specify only highest)		16a. Dece	dent's Usual Occ	upation e during most o	of working	16b. Kind of Bu	usiness/Indu	istry	
event, the Medical	Elementary/Secondary (0-12)	Cotlege (1-4or 5-	4)	kind of work don DO NOT use retiremaker	red)		Own 1	Home		
# O	8	-1	Home	emaker	40.00.00.00	A. 200				
To Be	17. Father's Name (First, Middle, La Joseph O'Keefe	s()				s Name <i>(First, Middle</i> Alma Brudo		10)		
T Trauma	19a. Informant's Name/Relationship Patricia DeGraw/					or Rural Route Numb 1timore, 1				
y injury or off	20e. Method of Disposition  1 Buriat 2 Cremation 3  4 Donation 5 Other (Spe	cify)	Gardens	matory or other p	h Cemet	ery 9/16/0 John C. I	1	more,		
2 25	July W	Mes		6415 Bel	air Roa	d Baltimo:	re, Mary	land 2	21206	
nding physician and use as the bunal-transit aution and use as the bunal-transit arrived and use arrived and use arrived and use arrived and use arrived and use arrived arrived and use arrived and use arrived and use arrived arriv	Immediate Cause (Finat disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	6. KE12	Due to (or as a conse POTHY Due to (or as a conse URE 1 Due to (or es a conse	quenca of): RO(D). quenca of): D1SOR						
the attendii hed for use ysiclar/	Pert II. Other algnificant conditions	contributing to death hu	t not resulting in the u	inderlying cause r	riven in Part i	23b. Dio	I tobacco use co	ntribute to	the cause of death?	
F .							Yea 2 No	3 Probe	/	
has been sign ge 2 should be mpleted by						perl	s an autopsy formed?	avai	re autopsy findings lable prior to upletion of cause eath?	
rector, per rector, per	25. Was case referred to medicat				26. Place	of Death (Check only				
After this funeral di	examiner?  1 Yes 2 No  27. Manner of Death  11 Natural 5 Pending 2 Accident investigat	Hospitat: 1 Inpatier  28a. Date of Injun (Month, Day)		of 28c. Inj	other: 4 Nurs	sing Home 5 ☐ Res 28d. Dascribe				
al Direction by	3 Suicide 6 Could not determine		ry - Al home, farm, st (Specify)	reet, factory, offic	9		(Street and Numb own, State)	per or Rural	Route Number,	
Puner pletely fill edicai	29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner stat	examination end/or in	h occurred at the ivestigation, in my	time, date and opinion, death	placa, and due to the occurred at the time	cause(s) and ma , date and placa,	anner as sta and due to t	ited. the cause(s)	
Ne Me	29b. Signeture and title of certifier			29c. Lice	nse number		29d. Date signe	d (Month, D	lay, Year)	
1	Sainde	r le sul	en MI	0 02	2718	1	9/15/1	00		
07/	Sairder	o completed cause of de	2 Mar	leef	Vlore	Balti	vee r	10	21222	
State Registrar	31. Date filed (Month, Day, Year)	2000 224	r's Signature	Spa	cks					

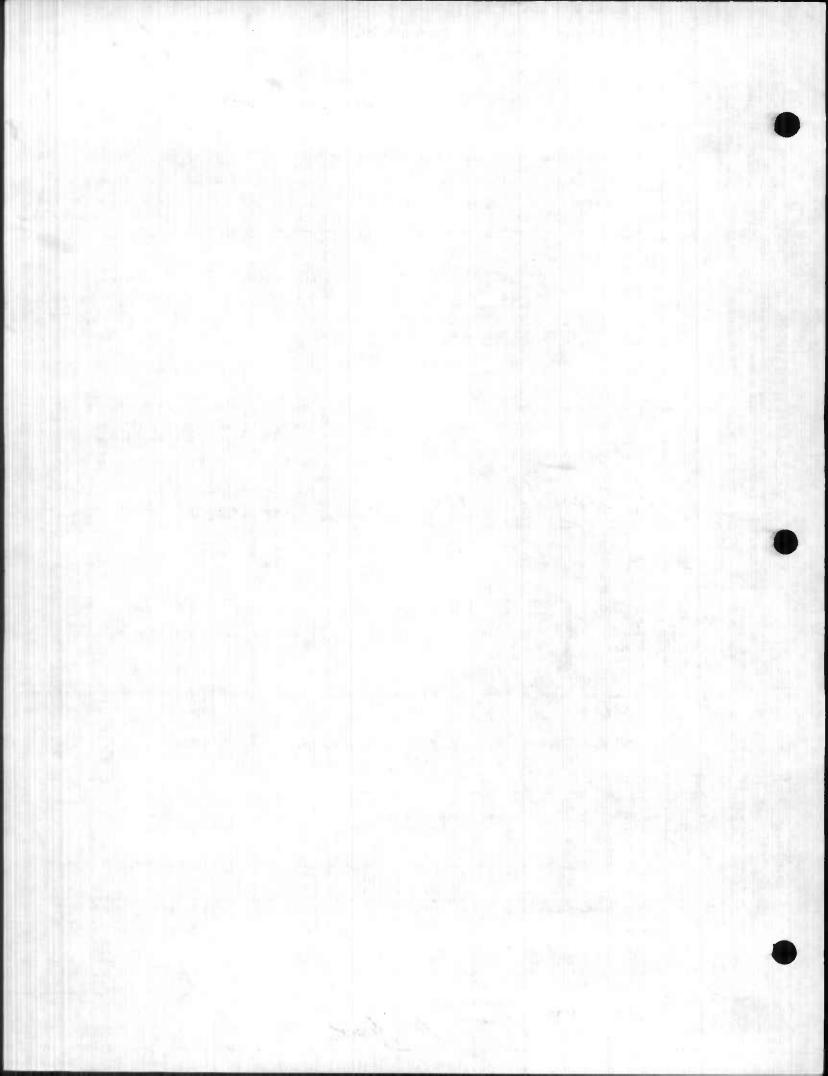


State of Maryland / Department of Health and Mental Hygiene

						Ce	rtifica	te of	Death			Reg. No.		61467	
Physicia /Medica	_	Decedent's Neme (First, M	ddle, Las	MAR	Y J	SEABO	OLT-	HARRI	SON		2. Dete of De Sept.	17 <sup>Day</sup> 20	O <sup>V</sup> O <sup>ar</sup>	3. Time of Death 2:03 am	
Examine	-	4a Facility Name (If not institu 317 Ma								sex	ocation of Dee			imore	
Funeral Director		5. Sociel Security Number 233–38–5888	6. Se	9x □ M 2 <b>2</b> 5F	7. Age (In yr.	s. last birthday)	Month:	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Dete of Bi (Month, D July	rth ey, Year) 24 1923		nplece (Stete or Foreign untry) tVirginia	
death with the Manyland ime 23e or 28e4 show creat be nothed at		Usual Residence of Decedent 10a. State 10b. Cou	•	imore	10c. 0	City, Town or Lo	ocation	Es	sex					10d. Inside City Limits 1 ☐ Yes 205No	
th with the Maryla 23a or 28a-1 should be not the	I Direc	10e. Street and Number 317 MArgare	et Av	ve.			10f. Z	ip Code	221			10g. Citizen of		untry?	
or ha	by Funeral Director	11. Marital Status  1 Never Merried 2 N  3 Nover 4 Divor	larried		2.⊠No ve		If Yes, sp	edent of H	ispanic Ori	igln? (Spi n, Puerto	ecify Yes or N Rican, etc.)	o- 14. Ra	ce - Amer	- American Indien, k, White, etc. White	
21215-0 d within 72 ho giene.	Completed	15. Dece (Specify only hig Elementery/Secondery (0-1	hest grad	ucation de completed) College (	1-4or 5+)	16a. Dece (Give life.	dent's Us kind of w DO NOT	uel Occup ork done use retired	ation during mos	it of worki	ing	16b. Kind of B	Business/I	ndustry	
re, Maryland 21215-002 s 1 and 2 should be filed within 72 hours Health and Mental Hygiene. tem 27 is marked other than "naturel; other traumatic event, the Medical En	Be	12th 17. Fether's Name (First, Midd	lle, Last)			Se	elf−e	mploy		er's Neme	e (First, Middle	Tax a, Maiden Sumer	Work		
Maryland d 2 should be flight and Mental Hy 7 is marked other traumatic event	2	George 19a. Informent's Neme/Releti	onship (7	ype, Print)			ng Addre	ss (Street	end Numb		OSA M N	Monk ber, City or Town	n, State, Z	"ip Code)	
0 80 = 8		Karen Taylor  20e. Method of Disposition  XXBuriel 2 Cremetic	n 3 🗆	Removal from	State 20b.	Plece of Disponentery, cre	osition (N metory or	eme of other plea	ce)		Dete Dete	20c. Location			
Baltimore, permit. Pages 1 a Department of Hee Important: if item any injury or othe once.		4 Donetion 5 Other (specify)  Gardens of Faith Cemetery9/21/2000 Ross  21. Signeture of Funeral Service Licensee  Connelly Funeral Home of Essex  300 Mace Ave. Baltimore Md. 212  23a. Pertl. Enter the disease, or complications that caused the death shock, or heart feiture. List only one cause on each line.												le MD	
Physician /Medical Examiner	ner	234. Pert I. Enter the disease shock, or heart feilure. I Immediate Cause (Finel disease or condition resulting in death)	of con	LONC	ONI	ANY (or es a conse	A	NS	SUCH 4S	Y	Dist=	ASE		Approximate Interval Between Onset and Deeth	
X 58/50 entificate be ling physicia	an/Medical Examiner	Medical	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest	{	c		(or as a consector es e consec								
dS, P.O. BOX ires that the death cent signed by the attendin d be detached for use	hysicia	Part II. Other algnificant cond	itions co	entributing to d	eath but not re	esulting in the u	ınderlying	ceuse giv	en in Part	1.		tobacco use co		to the cause of death?	
Hecords, P. he law requires that e has been signed b age 2 should be deta	Completed by Physician	RESPINA	10	ry p	mily	nt,	Otto	ron	lic		24e. Wa	s en autopsy formed?	24b.	Were autopsy tindings available prior to completion of cause	
Vital Rec	Comp	HYPEN	21	V Sic							10	Ives all No		of death?	
- Z 50 5	To Be	25. Was case referred to med examiner? 1 ☐ Yes 2 ② No	-	Hospitel: 1 🗆	Inpatient 2	□ ER/Outpatie	nt 3 🗆 (	DOA Oth	051		n (Check only	one) sidence 6 🗆 Ot	ther (Spec	cify)	
DIVISION O  The Hospital or Attending Ph in 24 hours after death. The Funeral Director: After th pletaly filled in by the funeral		E LI MODIOGIA	ding stigetion	(Mon	of Injury th, Dey Year)	28b. Time of Injury	М		y et k? Yes 2 □	No		how injury occu		Control Number	
DIVI pital or At oral Direct filled in by	Certif	4 ☐ Homlcide det	ermined	build	ing, etc. (Spec				no dete		City or To	own, Stete)		etated	
DIVISION To the Mospital or Attending I within 24 hours after death. To the Funeral Director: After sempletaly filled in by the funeral process.	Medical		at Exam	iner: On the b			vestigetic		pinion, dee			ceuse(s) and m , date end plece 29d. Dete sign	, and due	to the cause(s)	
	1	30 Name and address of con-	on who a	Can f	se of death fit.	am 23a) /Time	Print\	DE	310	76	>	4/181	100		
1712		30. Name and address of pers					un	(m	ud,	No	2127	77			
State	е	31. Date filed (Month, Day, Ye SEP 1 0	2000	32.	legistrer's Sig	nature									

DHMH 16 Rav 6/95

ORIGINAL



AMEND ITEM: 1 PER PHY G78tate of Manyland Pepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** SUSAN-SHIPLEY - SUSIE I. SHIPLEY Month 450 PM 2000 Sept. /Medical 4e. Fecility Neme (If not institution, give street end number) 2825 Lodge Farm Road 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 5. Sociei Security Number 8. Date of Birth (Month, Dey, Year) June 24 1929 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Deys 1 M 2 TF 217-22-8754 Yrs. 71 Director MAryland Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show items 23s or 28s-f show Director 1 ☐ Yes 2 No Baltimore Baltimore the 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2825 Lodge Farm Road Funeral USA 14. Race - American Indien, 21219 12. Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) traumatic event, the Medical Examiner Bieck White etc. filed within 72 hours after 1 □ Never Memed 2 □ Merried 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 21215-0020 6 1 ☐ Yes 2 No Specify: þ White Specify: 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 5th Homemaker own home Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Peges 1 and 2 should be fill ment of Health end Mantel Hant: If Item 27 Is marked oth jury or other traumatic even Charles Mowbray Artie McDorman 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Barbara Dempsey / daughter 8 Debkay Court Baltimore. MD 20e. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Dete 1 2 Burial 2 Cremetion 3 Removel from State Department of important: If any injury or MeadowridgeCemetery 9/19/2000 Baltimore MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility
Connelly Funeral Home of Essex 300 MAce Ave. Baltimore MD 21221 lerry 23e. Pert1. Enter the disease, or complications that caused the down bo not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Physician Cardiopulmonay Failure /Medical Immediate Ceuse (Final 6 hours disease or condition resulting in death) Examiner Due to (or es e consequence of): Rheumatoid Arthotis The lew requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest the bunal-tran Due to (or es e consequence of): esophagitis Box 68760, Candida ata has been signed by the attending physician page 2 should be detached for use as the buna Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown hypothypialsm, Sinusitus. Records, Completed by intersectial fibrisis, anemia 24b. Were autopsy findings aveilebie prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 2 No Division of Vital Physician: Be 25. Wes case referred to medical 28. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1□ Yes 22 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 After this the funeral 27. Menner of Deeth 1 W Netural 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation To the Hospital or Attenumwithin 24 hours after death.

To the Funeral Director: Af completely filled in by the fi death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 112 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29b. Signature and title of cartifier 29c. License number 29d. Dete signed (Month, Day, Year) UPIN RESODO 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

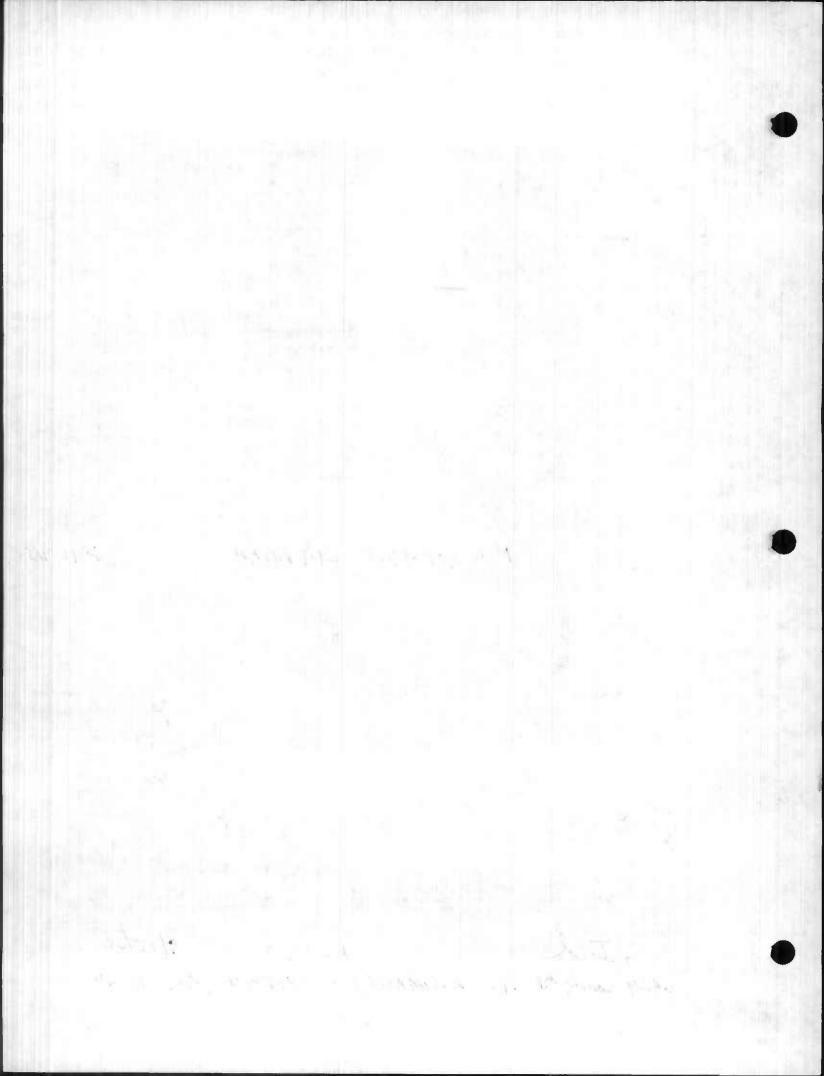
Peter H. Cheng MD, 5305 Hopkins Bayua Cirle, Baldon 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Registrar

CHARLES ADON with the same - finding a reason and a second of Samuel Same Solid, you had been KACAMAN SA CAMAR San the Barrell of the Commence of the Commenc a course in many that years a wilesally them? when 642 B. S. S. V 2,443 Mr. Styring Brown Service Co. 

State of Maryland / Department of Health and Mental Hygiene

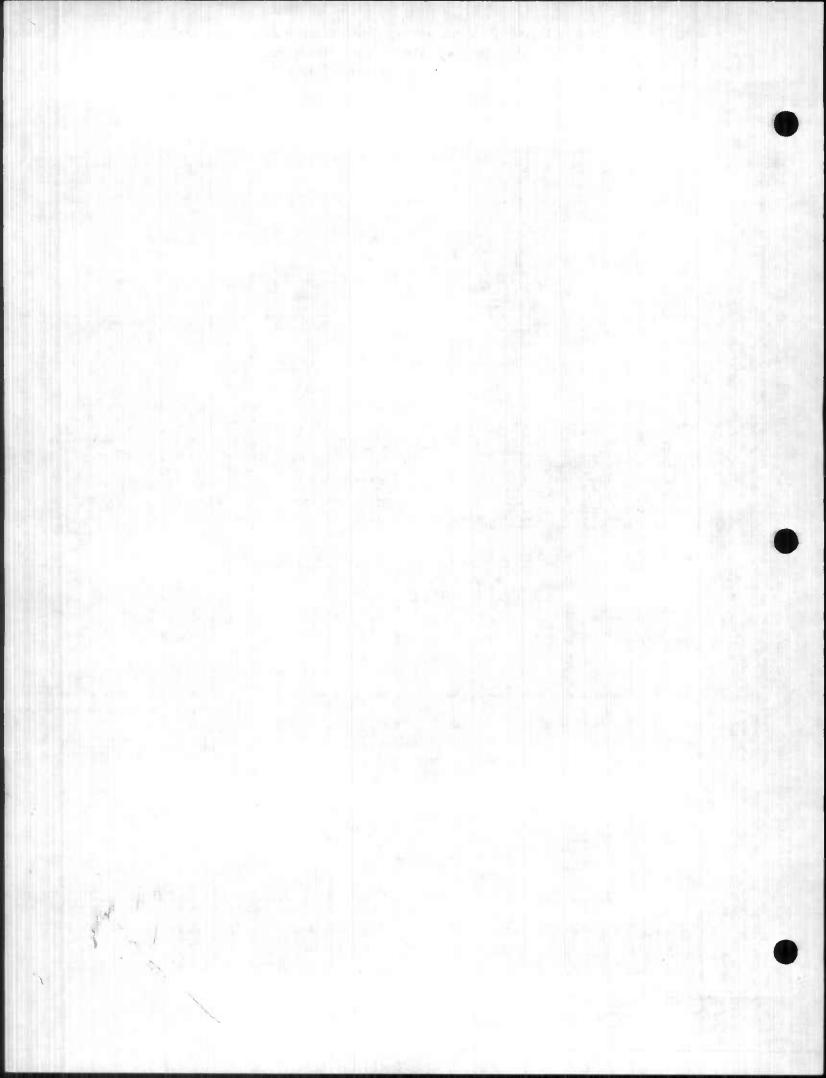
Amended 1	Item#12 perF	HG/8/ 9/19	/2000 EW		Certific	cate of	Death		Reg. No.			
Physician /Medical		ne (First, Middle, La JA(			SAVAG	Ε			2. Date of Deeth SEPT 15 <sup>Day</sup> 2000 <sup>Year</sup> 3. Time of Death 2:45AM			
Examiner	10222	(If not institution, gh	e street and number,	)			BALTIM		BAL	ty of Deeth		
Funeral Director	5. Social Security 217–26–2	2126	Sex 1 DM 2 DF	ge (In yrs. last bin	Yrs. H U	Inder 1 Yeer oths Days		Min. 6. Dete of (Mont) 4/12	of Birth 1, Dey, Year) 2/1931	9. Birthp Cour MD	place (State or Foreign ntry)	
4 show fed.at	Usual Residence	10b. County BALTIMOR	RE	10c. City, Town					1	10d. Inside City Limits 1 ☐ Yes 2 No		
a or 28e-t s at he notified if Director	10e. Street and No. 8712 IN	umber WOOD ROAI			10f. Zip Code 21244					10g. Citizen of What Country? USA		
at, or teme 23a or 28a-t show Examiner must be notified at by Funeral Director		rrled 2½ Merried 4 □ Divorced	12. Wes Decedent Armed Forces' 1 X Yes 2  If Yes, Give Yeer or Detes:	NARMY Navy	If Yes, specify Cuban, Mexican, Pueno Rican,					or No- 14. Race - American Indien, Black, White, etc.  Specify: WHITE		
t, the Medical E Completed	(Spe	15. Decedent's Excify only highest grandary (0-12)	ducation ade completed) College (1-4or	54)	16a. Decedent's Usuel Occupation (Give kind of work done during most of working iffe. DO NOT use retired) SETTLEMENT OFFICER					Business/Ind		
B see		(First, Middle, Last	)	35		ENT OF		Name (First, Mi	iddle, Maiden Sume	im <i>e)</i>	115	
w traumatic To		Neme/Reletionship (							umber, City or Town	n, State, Zip	Code)	
ury or oth	20a. Method of Dis 1 X Buriel 2 4 Donation	20b. Plece of cemeter BALTIM	ry, crematory	or other ple	ece)	9/17/0	Date 20c. Location - City or Town, State /17/00 REISTERSTOWN, MD					
any inj	21. Signature of	uneral Service Lice	Cettle	1					INSON & BI			
use as the burishment	Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.											
ed by the attended for undetached for undetached for undetached for undetached by Physician	Part II. Other sign	ificant conditions	contributing to death I	but not resulting in	n the underly	ing cause g	iven in Part I.	23b.	23b. Did tobacco use contribute to the cause of			
2 should be pletted by							at .		24a. Was an autopsy performed? 24b. Were auto available completion of death?			
Physician: this certifical director. To Be	27. Manner of Des 1 Natural 2 Accident 3 Suicide	ØNo	OB Diseased in		Time of njury M	28c. Inju	ther: 4 Nurs ary at ork? Yes 2 No	ing Home 5 28d. Desc	Residence 6 O	ther (Special		
Within 24 hours after loads. To the Funeral Director: After completely filled in by the funeral Medical Certification	4 Homicide	Certifying Pl	building, e	ic. (Specify) of my knowledge	, death occu	rred at the t	ime, date and p	place, and due to				
To the Funeral completely filled Medical C	(Check only one)  29b. Signeture en	d title of certifier	miner: On the basis of end manner si	teted.		29c. Licer	se number	0	29d. Date sign	ned (Month,	, Day, Year)	
State	30. Name and add CARY 31. Dete filed (Mo	coller,	completed cause of PP 6 7 9	N - Cur	(Type, Print)		BAL	MOLO	5/10.	2120	4	
Registrar	5	EP 1.9 20	00 00	wa f	D /	port	16					

ORIGINAL



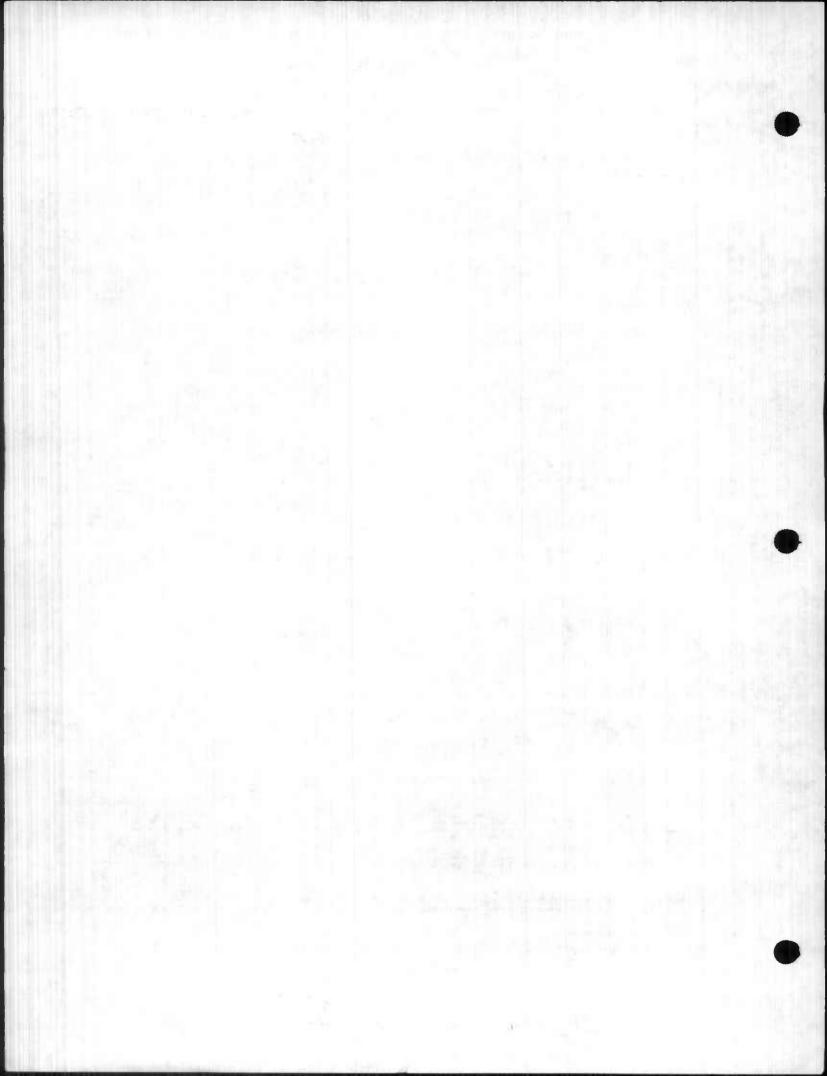
State of Maryland / Department of Health and Mental Hygiene 00 29476

	Certificate of	r Death	Reg. No.									
Physicia	1. Decedent's Name (First, Middle, Last)  ARON STERN	2. Data of D Month	Dev Year									
/Medic		SEPTI	EMBER 15,00 4:46 PM									
Examin	4a Facility Nama (If not institution, give street and number)	4b. City, Town, or Location of Dea										
7.4	NORTHWEST HOSPITAL CENTER	RANDALLSTON	NA BALTIMORE									
Funeral	Months Day	ar If Under 24 Hrs. 8. Deta of B s Hours Min. JAMonth 6	9. Birthplace (State or Foreign CZECHOSLOVAKIA									
Director	180-24-7203 1 18 18 18 18 18 18 18 18 18 18 18 18 1	UAIN 6	1906 CZECHOSLOVAKIA									
2 .	Usual Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location		10d. Inside City Limits									
sho sho sho			1 ☑ Yas 2 ☐ No									
2 TH	PA PHILADELPHIA PHILADELPHIA  10e. Street and Number  10f. Zip Code		^									
with the Marylan s or 28a-4 show be notified at	10f. Zip Code		10g. Citizen of What Country?									
	1523 RIPLEY STREET 19111		USA									
tam tam	Armed Forcas? If Yas, specify Co	f Hispenic Origin? (Specify Yas or N Joan, Mexicen, Puerto Rican, etc.)	Black, Whita, atc.									
20 mm	tf Yes, Give 1 ☐ Yes 2 € N	o Specify:	Specify:WHITE									
hours aft			10h Mind of Business Hadrotes									
2 2 mg	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  PROPRIETOR	upation le duning most of working red)	16b. Kind of Business/Industry									
TZ Dan Dan	Elementary/Secondary (0-12) College (1-4or 5+)	100)										
D Photo		18. Mother's Name (First, Middle	DELI Maiden Sumamel									
ad in see												
T Ment	LAZER STERN	BOSCHA	(UNKNOWN)									
Maryland 21215-0020 3 2 should be filed within 72 hours at th and Mental Hygiene. 7 is married other than "natural", or traumatic event, the Medical Easin		et and Number or Rurel Route Num										
A SEE		E COURT ELLICOTT	20c. Location - City or Town, State									
Pages ment of P tant If No	1 Bunal 2 Cremation 3 Removal from State	AT DADY 0/17/00	TREVOSE, PA.									
	4 Donation 5 Donat (openly)		INEVOORY PA.									
Ball Separation of the separation 1. Signatura of Funeral Regulds Licensee 22. Nama and Ado	rass of Facility SOL LEVIN	SON & BROS. INC.										
- 402.00			KESVILLE, MD. 21208									
	23a. PARTY Enter the disease, or complications that ceused the death. Do not anter the mode of displace, or your failure. List only one cause on each line.	ying, such es cerdiac or raspiratory	arrest, Approximate Interval Between									
Physician	1		Onset and Death									
/Medical	Immediate Cause (Final disease or condition ASPIRATION PINE	OMIONIA										
Examiner	Immediate Cause (Final disease or condition resulting in death)  a. ASPIRATION PINE  Due to (or es a consequence ot):											
D 4	- MYOCARDIAL		0 N									
58760, icate be avacuted physician and s the burial-transit	Sequentially list conditions, if any, leeding to immadieta cause. Enter Underlying											
sian a												
X 68 / 60, sertificate be asscur ding physician and se as the bunal-trar	Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence ot):											
	Cause (Diseese or Injury that initiated events resulting In death) Lest  Due to (or as e consequence ot):											
0 2 5 5												
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I. 23b. Dlo	tobacco uss contributs to the cause of death?									
that the detache	2000	10	Yss 2□ No 3□ Probably 4⊠ Unknown									
E X TO	PACER											
KECOLGS, he law requires the has been signed age 2 should be			s an autopsy ormed? 24b. Were autopsy findings available prior to									
law re law re as be s 2 sh	a l		completion of cause of death?									
The law ate has page 2	Completed	10	Yes 2♥No 1□Yes 2□No									
VITAL The sicien: The certificate irrector, pag	0 25. Was case referred to medical examiner?	26. Place of Death (Check only	one)									
	examiner?  1  Yas 2 No	Other	sidence 6 Other (Specify)									
Phys or this			how injury occurred									
dling Ith.	1 tigNatural 5 ☐ Pending (Month, Day Year) Injury W 2 ☐ Accident investigation M 1	Tork? ☐ Yes 2 ☐ No										
DIVISION  I or Attending  after death.  Director: After d in by the fune	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, tarm, street, fectory, office		(Street and Number or Rural Route Number,									
d'in d'in	27. Manner of Death  1 Monatural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day Year)  28b. Time of Injury M 1  28c. Place of Injury - At home, tarm, street, fectory, office building, etc. (Specify)	City or 1	own, State)									
spite nersi		time, date and place, and due to th	e cause(s) and manner as stated.									
DIVISION To the Hospital or Attent within 24 hours after deat To the Furness Director: completely filled in by the	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the pasts of examination and/or investigation, in my and manner steled.	y opinion, death occurred at the time	, dete and place, and due to the cause(s)									
Vithir Fo th	₹ 29b. Signature and title of pertitier 29c. Lice	nse number	29d. Dete signed (Month, Day, Year)									
1,0	1.5. RAO.TO O. OL	13462	SEPTENBER, 15,00									
Orn-		5 5 0										
OW	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   C. I. N. T. E.	BANDALLS	TOWN, MO									
Stat	31. Date filed (Month, Day, Year) 32. Registrar's Signeture	-										
Stat Registra	SEP 1 9 2000 Dereva & Sol	ules										



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** SEPT 15 2000 3:34AM /Medical 4b. City, Town, or Location of Death 4e Facility Name (# not Institution, give street and number) 4c. County of Death Examiner 10 EAST LEE STREET #2405 BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth AUG 10 1906 9. Birthplace (State or Foraign **Funeral** 94 Months Days Hours Min. POLAND 1□M 20 F Yrs. Director 212-26-0238 Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai", or items 23s or 28s-f show Exemple: must be notified at BALTIMORE BALTIMORE 1 ☐ Yes 2 1 No Director 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3705 BRETON WAY 21208 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 11. Marital Stetus Peges 1 and 2 should be filed within 72 hours after nent of Health end Mental Hygiene. Int: If Item 27 la marked other than "natural", or Ne 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: WHITE by 3€ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) (UNKNOWN) HARRY MASKOWITZ DORA 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) permit. Peges 1 and 2 a Department of Health er Important: If Item 27 is any injury or other trau page. ELAYNE HETTLEMAN/ DAUGHTER 3705 BRETON WAY BALTIMORE, MD. 21208 20b. Place of Disposition (Neme of 20c. Location - City or Town, State 20a. Method of Disposition Dete OHEB SHALOM MEMORIAL PARK 9/17/00 1 Burial 2 Cremetion 3 Removel from Stele
4 Donation 5 Other (Specify) REISTERSTOWN, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert tailure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical accident Corebrovesculer **Examiner** Due to (or as e consequenca ot) Examine Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Last Box 68760. physician Physician/Medical Due to (or es e consequence of) the P.O. 9 Part ft. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown p Records, 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 1 Yes 2 No t ☐ Yes 2 ☐ No of Vital Be 25. Was case referred to medical 26. Plece of Death (Check only one) SON IN LAW Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) RESIDENCE 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Division or Attending 5 Pending Investigation 1 Naturel 1 Yes 2 No after death. 2 Accident Director: 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled is 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dele and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 9/15/00 MD 4086 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) MIGUEL SADOVNIK 1838 GREFNE TREE ROAD #135 - BALTIMORE, MD 21208 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item# 30 perVERBAL G787 9/19/2000 EW Certificate of Death 1. Decedent's Neme (First, Middle, Last). 2. Date of Death 3. Tima of Death Month Day **Physician** Septembe arie /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Randallstown Baltimore 7. Age (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□ M 2□ F Yrs. Director 64 212-34-5049 Jan. 27 1936 Delaware Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Director MD Baltimore Baltimore 28a-f 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? iner mant be n 8815 Stone Ridge Circle, Unit 101 21208 USA Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, atc. the Medical Examiner 72 hours after 1 ☐ Yes 2 ☐ X\\0 If Yes, Give Year or Detes: 1 Never Merried Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: White Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Med within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Interior Decorator 12 Interior Design n/a 17 Father's Neme /First Middle Last 18. Mother's Name (First, Middle, Meiden Sumeme) Pages 1 and 2 should be III ment of Health and Mental H aunt: If Item 27 is marked oth lary or other traumatic even 88 John Montcalm Margaret Dimartino 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Carroll X. Skurzynski/husband 8815 Stone Ridge Circle, Unit 101, Balto., MD 21208 20a. Mathod of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 9/21/00 Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD 21. Signeture of Fund 22. Name and Address of Facility Lemmon Funeral Home Michael J. lagle 10 W. Padonia Rd., Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximeta Intervat Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Pulseless Electrical Activity (PEA) Examined Due to (or as a consequence of): Examiner Coronary Artery Disease sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Dysrhythmia physician s the burial Box 68760. Physician/Medical Due to (or as a consequence of): 88 980 P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yea 2 ☐ No 3 ☐ Probably 1 ☐ Unknown Records. by 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: director. 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 XNo Certification: To 1 ☐ Inpatient 2 💆 ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Plece of Injury - At home, lerm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital 29a. Certifier edical 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. \$ 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 6 30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

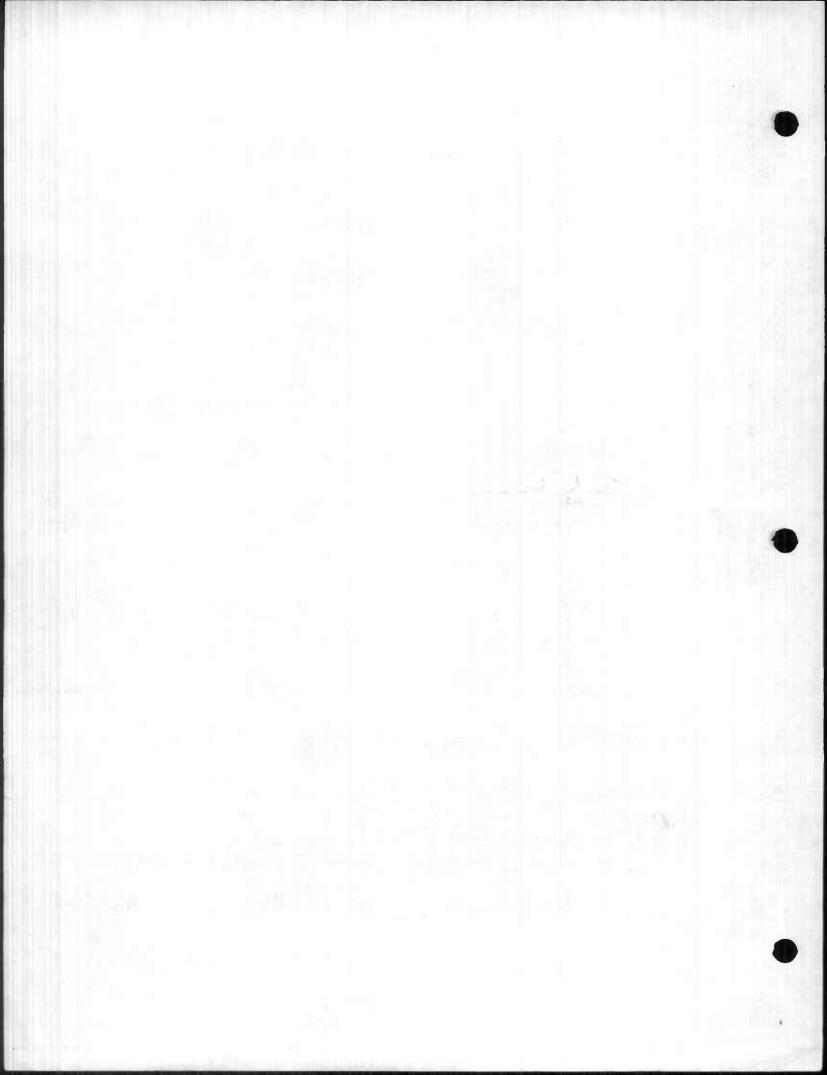
Registrar

CYNIHIA B WEBB 23: 31. Date filed (Month, Day, Year) SEP

232 Lakeside Dr, Horsham, PA

2000

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

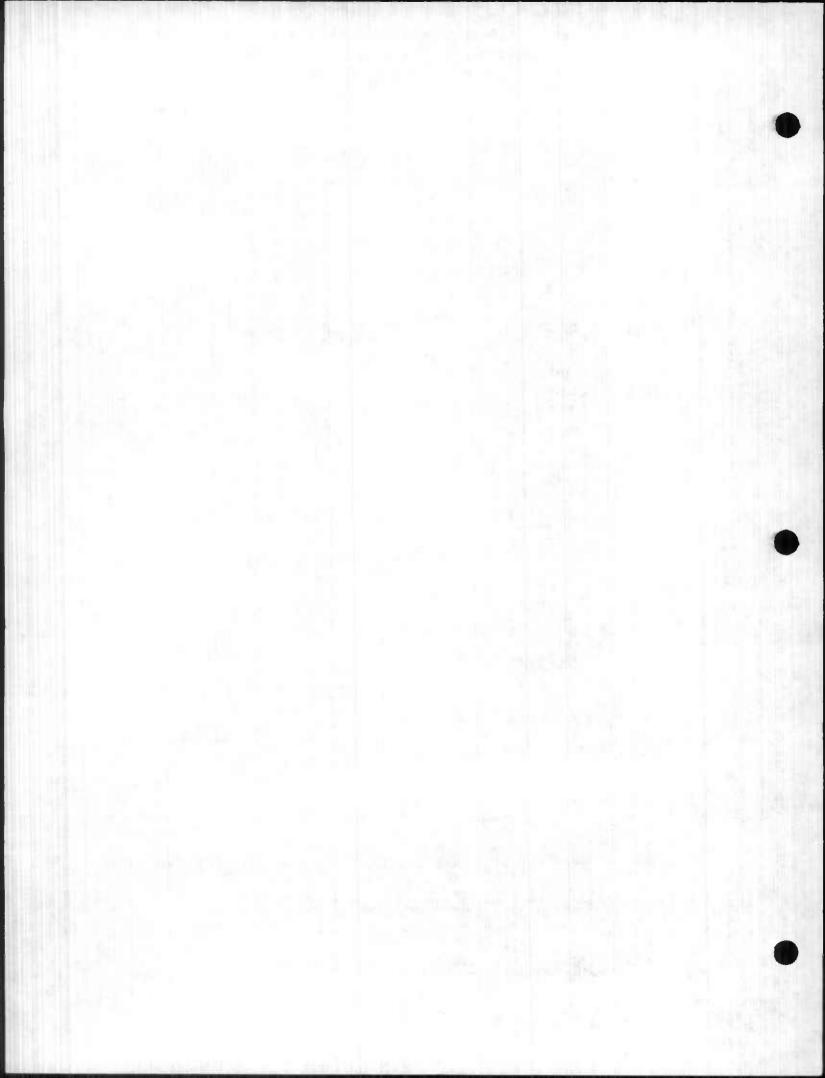
Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth **Physician** Wanda Hedwig Scepaniak 17 2000 Sept. 7:10 AM /Medical 4a Facility Name (If not Institution, give street end number) 4h City, Town, or Location of Death 4c. County of Death Examiner St. Joseph's Hospital Towson Baltimore if Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplaca (Stete or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Deys Hours 10M 2QF Yrs Director 212-09-8657 83 Oct. 11 1916 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ma 23s or 28s-f show mast be notified at 1 Yes 2 No Director MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1009 Roxleigh Rd. 21286 USA Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Biack, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? 11. Maritei Stetus 1 Yes 2 No If Yes, Give Yeer or Detes: filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0020 Specify: White by 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 n/a Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hyg important; if then 27 is marked other any injury or other traumerised other gass. 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Joseph Jasinski Mary Popiacka 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Jacqueline Gilbert/daughter 1009 Roxleigh Rd., Towson, MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriei ② Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Balto. Wash. Crematory 9/18/00 Laurel, MD 21. Afgrature of Fungral Service Courses

Bryan W. Clary

23a. Partt. Enter the disease, or compicious shock, of heart failure. List only one 22. Name end Address of Fecility Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093 it caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest Approximate Intervai Between Onset and Deeth **Physician** immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequenca of) Physician/Medical Examiner requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in itilated events resulting in death) Last Due to (or es e consequence of) 68760. the attending physician as the Due to (or es a consequence of): Box use 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably Winknown signed by I þ Records. 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? Be Completed 1 Yes 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director; to completely filled in by the funeral director; to 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Hospitel: 1 Yes 2 100 1 Sinpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of Injury at Work? Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, Ierm, street, fectory, offica building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, deeth occurred at the time, dete end placa, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end placa, end due to the cause(s) and menner stated. 29e Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Susan Meltzer, M.D. 12221 Tullamore Rd., Suite 3, Timonium, MD 21093 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State SEP 1.9 2000 Sener Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 17, 2000 12:05pm Steide1 Dorothy Anna 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Baltimore Manor-Care Towson Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days 1□M 2♥F Yrs 214-14-7195 87 Oct 13, 1912 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 No Baltimore Maryland n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21211 USA 3838 Roland Avenue, apt. 203 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 🔯 No If Yes, Give 1 Never Married 2 Married n Yes, Give Year or Dates: Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Illustrator Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Deitz Steide1 Mollie Leonard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 9 Ballyhean Court, Timonium, MD V. Louis Stuckey/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20e. Method of Disposition 9/19/00 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland Baltimore-Washington Crematory 21. Signature of Funeral Service Lightney 22. Name and Address of Facility Lemmon Funeral Home Clary 10 W. Padonia Road, Timonium, MD 21093 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause do each line. Approximate Interval Between Onset and Death Immediate Chase (Final disease or condition resulting in death) Cesebrovasaden Due to (or as a consequence of): Sequentially tist conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Dehydratus Due to (or as a consequence of): Bralmia Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco uas contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown PI feare Jomt 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 🗓 No 25. Was cese referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be file.
Department of Health and Mertal Hy,
Important if New 27 is marked other any Injury or other traumatic event.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or learns 23s or 28s-f show the Medical Examiner must be notified at

Maryland 21215-0020

Baltimore,

Box 68760

P.0.

Division of Vital Records.

Directo

Funeral

À

Examiner Physician/Medical 3 p Completed Be this Certification:

or Attending Patter death. To the Hospital of within 24 hours at To the Funeral D completely filled it

edical State Registrar

29b. Signature and title of certifier

5 Pending

investigation

6 Could not be

29c. License number D 31464

1 Yes 2 No

1 A Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medicat Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

September 18, 2000

281. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

Shoaib Hashmi, MD 821 N. Eutaw St., Baltimore, MD 21201

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year)

1 Natural

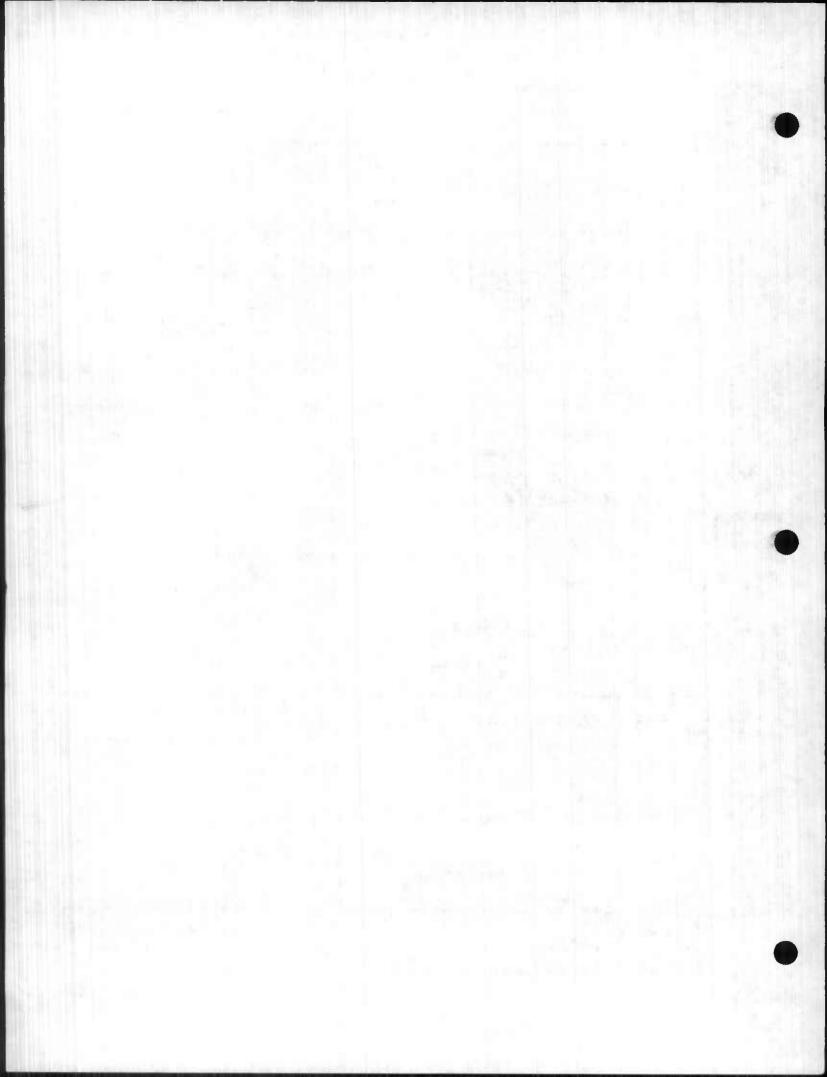
2 Accident

3 ☐ Suicide

29a. Certifier

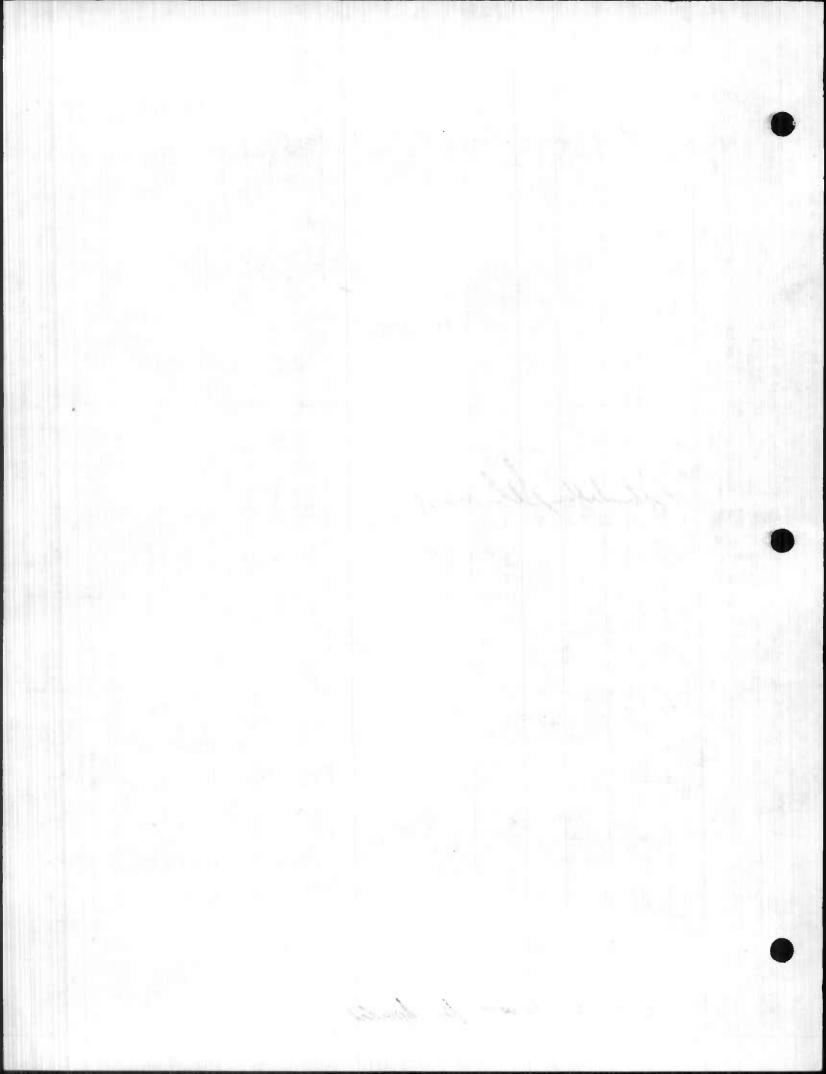
4 Homicide

32. Registrar's Signature 2000



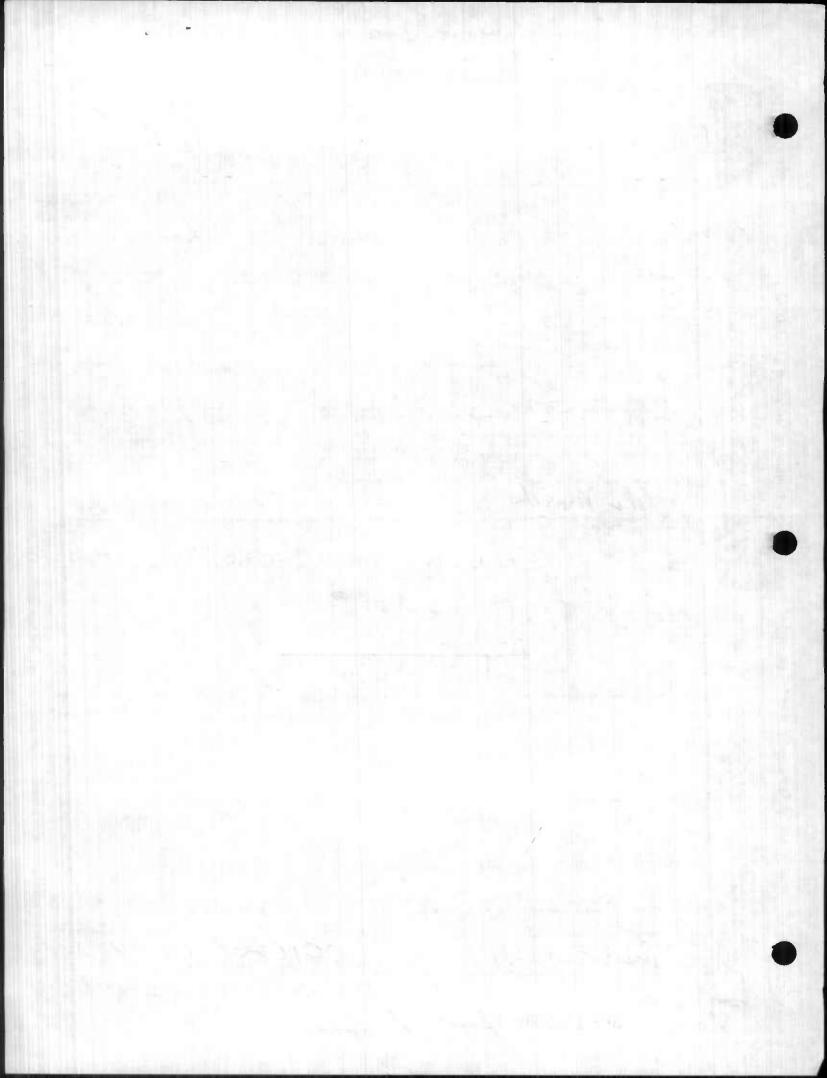
State of Maryland / Department of Health and Mental Hygiene 00 29181.

	Certificate of Death		Reg	a. No.	0 2	2401						
ician	Decedent's Neme (First, Middle, Last)     Carol Francis Sheets		te of Death onth	Day BER 13	Year 2000	3. Time of Deeth						
dical niner	4e Facility Neme (If not institution, give street and number)  4b. City, Tox	own, or Location	of Death	4c. County		re City						
	5. Social Security Number  6. Sex 1 M 2 F 7. Age (In yrs. last birthday)  7. Age (In yrs. last birthday)  Wonths Days Hours  Usuel Residence of Decedent		te of Birth onth, Day, 1 Jun 6,		215	lece (Stete or Foreign try) sachusetts						
or	10a. Stete 10b. County 10c. City, Town or Location				10	0d. Inside City Limits						
Director	MD Baltimore Baltimore  10e. Street and Number 10f. Zip Code		10	g. Citizen of \								
Dy ruinet as	3330 Wilkins Ave  11. Meritel Stetus  1 Never Married 2 Merried 3 Wildowed 4 Divorced  12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:  1 Yes 2 No Specify:	igin? (Specify Yen, Puerto Rican,	Spacific:			en Indien,						
-	15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)		10	Sb. Kind of Bo		lustry						
	12 Key Punch Ope 17. Father's Neme (First, Middle, Last) 18. Mothe	erator er's Neme <i>(First,</i>	Middle, Me									
1	Nicholas Francis Berry		Maria	n DeWo	lfe							
	19e. Informant's Name/Ralationship (Type, Print)  19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State,  Mr. Steve Spicer  307 Gun Rd. Arbutus, Maryland 21227											
ortant: If Nam Injury or oth 8.	20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removal from Stete 4 Donetion 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, cremetory or other place)  All County Cremation Services, Inc.   09/15/00 Sykesvil											
	22. Name and Address of Fecility  Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043  23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errast, interval Between the shock, or heart failure. List only one cause on each line.											
niner	Immediate Cause (Final disease or condition rasulting in death)  a. ASD DELLO Procus and Dua to (one's a consequence of):	Menja				Onset and Deeth  a days						
n/Medical Examiner												
hysicia	Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceusa given in Part I.	1. 23	23b. Did tobacco uss contribute to the cause of c									
Completed by Physician/	Seizne Disorder	24	le. Wes en	eutopsy ed?	ave	ara autopsy findings ailable prior to appletion of cause						
Comp	Dementia		1 🗆 Yes	2 No		death? ]Yes 2□ No						
Be	examparr	e of Death (Chec	ck only one	)								
n: To	27. Manner of Death 28a. Deta of Injury 28b. Time of 28c. Injury at	ursing Home 5		v injury occur		()						
lificatio	1 Matural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation 3 Suicide 6 Could not be detarmined 4 Homicide Suicide 6 Could not be building, etc. (Specify)	28t. Lo	cation (Stre	eet and Numb	ber or Rura	l Route Number,						
edicai Certification:	29e. Certifiar  (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deet	nd place, and du	e to tha cau	usa(s) and ma	anner as st and dua to	ated. tha causa(s)						
Med	29b. Signeture and title of continue 29c. License number DQ754	-/		d. Data signe Septen		Day, Year) 4 , 2000						
	30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)  OFETHA RAJA, 4367 HOLLIM PERRY RD	) BA										
tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature											



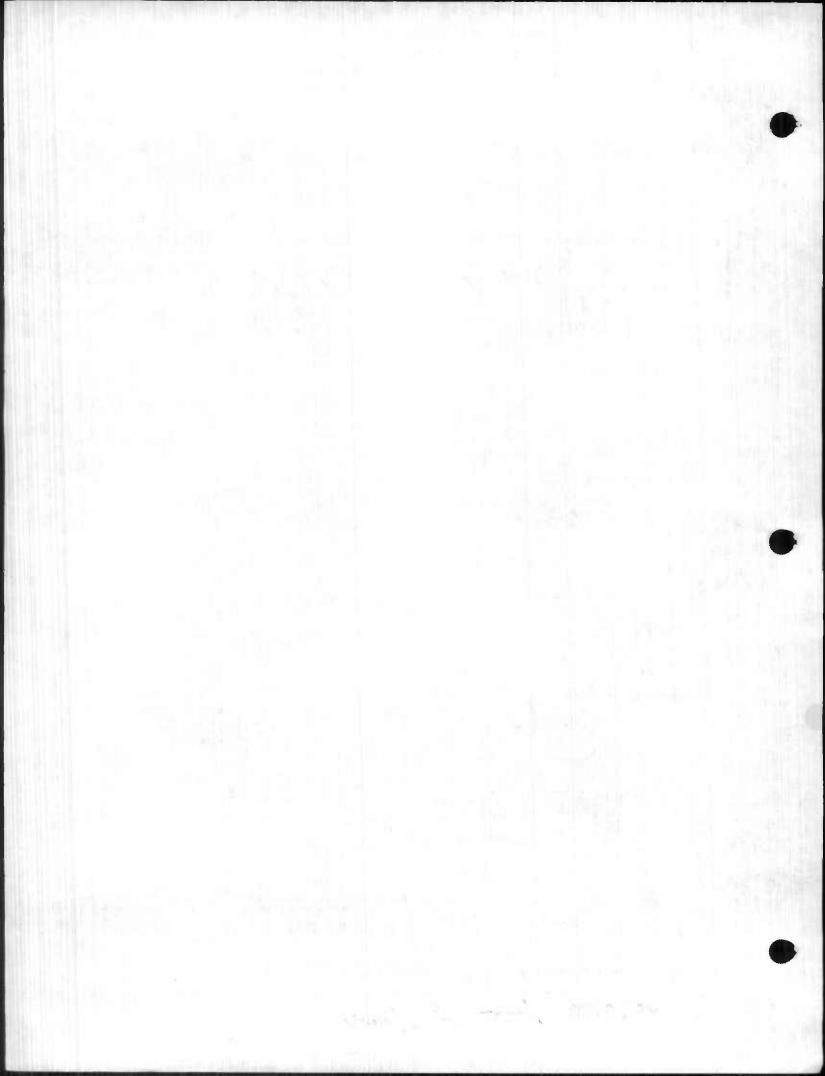
# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		AMEND#23A PER	R MD. G787 9				ficate of	Death		Reg. No.	4	9482
	Physician	1. Decedent's Neme				т. 1.	- 6		2. Data of De Month	12 200	Xear	3. Time of Death 9:00 a.m
	/Medical	4a Facility Name (If I	not institution, also		Earl	Taylo	r, Sr	4b. City, Town, or	,		-	9:00 a.m
	Examiner	1409 McCu						Baltimo		N/A		
100000	uneral rector	5. Social Security Nu 219-40-78	mber 6. Ser	7. Age	(In yrs. la 56		If Undar 1 Yee Months Days	r If Under 24 Hrs	8. Date of Bir		9. Birthp Coun	lece (State or Foreign
dand	show rd.st	Usuat Residence of D	10b. County		10c. City	Town or Loca	tion				1	0d. Inside City Limits
with the Maryland	or 28s-f sho or confed Director	Md	N/A	- 500	Balti	more						1)XXYes 2□No
4	or 28	10e. Street and Num					10f. Zip Code			10g. Citizen of W	nat Coun	try?
death w	ral l		illoh Str				212			USA	America	an Indian,
10	er, or flams 23a or 28a-f e Examiner must be repried by Funeral Director	11. Meritel Stetus  1 Never Merrie  3 Widowed 4	d 2 Married	12. Was Decedent E Armed Forcas?  1 X Yes 2 N If Yes, Give Yeer or Detes:			os Decedent of as, specify Cu  Yas 2 No	Hispanic Origin? (Steen, Maxican, Puer Specify:	to Rican, etc.)	Specify B	, White,	etc.
5-0 72 ho	"naturel", solical Exu	(Specif	15. Decedent's Edu	cation e completed)		16a. Deceder	nt's Usuel Occi	upetion e during most of wo red)	orking	16b. Kind of Bus	iness/Inc	lustry
121 vithin	A tre Modes	Elementary/Second		College (1-4or 5	+)		NOT usa retir		Miles III	POSTAL	SEI	RVICE
d 2 filled v	other t								me (First, Middle	, Maiden Sumeme	)	
ylan ylan Mental	marked off matic ever To Be	JAMES C	OUNTS					VANDE	LLA TA	YLOR		
Mar nd 2 sh	27 ie m r treum	19a. Informent's Ner LORRAINE			ER	19b. Meiling 1757	Address (Stree	et end Number of R	ural Route Numb	er, City or Town, 5		Code) 218
Baltimore,	int: If Hem iry or othe		sition Cremation 3 R		CO		tory or othar pi	ece) ETERANS	Date 9-19-00	20c. Location - C		wn, State
Balt Permit.	Important: I any injury o once.	21. Signature of Fun	erel Service License - Mer	ch		1	larch	ress of Fecility F/H West abash Ave		timore,	Md 2	21215
		23a. Pert1. Entar the shock, or heart	disaasa, or compli failure. List only or	ications thet caused na ceuse on each lin	the deeth.	Do not enter						Approximate Interval Between
/M	sician edical miner	Immedieta Cause (F diseese or condition resulting in death)	inei e	CARI	101	PULL	ION AK	By An	RRES	T	1	Onsat and Death
	je le					as a conseque	ence of):				1	A 2 4
petho	in and ist-transit Examiner	Sequentially list cond	ditions,	HYPERTE		es e conseque	ence of):					
50,	ouriat-	Sequentially list conditions, leeding to immoduse. Enter Underline Ceuse (Disease or Inc.)	nadiete ying niury									
ox 68760,	attending physician and for use as the bunal-transit clan/Medical Examir	thet initieted events resulting in death) La		Hy	11.5	as a conseque	inca of):	10x				20 YRS
Box death cen	d for use	Pert II. Other signific	ent conditions con	tributing to death by	t not resu	iting in the und	edving causes	niven in Part I	23h Did	tohacco usa con	tribute to	the cause of death?
P.O	signed by the attending d be detached for use a d by Physician/M	r atti. Other signific	ant conditions con	imbuting to death bu	t not resu	inig in the und	enying causa s	groot at Fact I.			3000	
Records,	shoul								24e. Wes	en eutopsy ormed?	av	ere autopsy findings ailable prior to mpletion of cause death?
	page 2	13 15 15 1							10	Yes 2000	1 (	☐Yes 2☐No
	is certificate director, pag To Be Co	25. Wes case referre	d to medical					26. Place of De	eath (Check only	one)		
of Vita	T de	1 Yas 2	lo F	lospital:		R/Outpatient	3LI DOA	Other: 4 Nursing		idence 6 Othe		y)
O'D'	After funeral	27. Manner of Deeth	5 Pending	28a. Dete of Injur (Month, Da)	Year)	28b. Time of Injury	28c. Inj W	juryat lork? □Yes 2 □No	28d/ Describe	how injury occurre	ed	
Division or Attending after death.	by the	2 ☐ Accident 3 ☐ Suicide	investigetion 6 Could not be	28e. Pleca of Inju	ry - At hor	ne fem stree			28f. Location /	Street and Numbe	or or Run	al Route Number.
DIV after	al Director: After to led in by the funeral Certification:	4  Homicide	determined	building, etc	. (Specify,		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			wn, Stete)		
Hospital     24 hours	To the Funeral Director: After completely filled in by the funer completely filled in by the funer completely filled in Certification			sician: To the best of ner: On the basis of and menner ste	examineti							
To the within 2	Toth	29b. Signeture and ti	tle of partifier	0 6		( A	29c. Lice	nse number	2/0	29d. Date signed	(Month,	Day, Year)
	111	The	Rand	Offe	m,	(11)	De	010	205	04-1	4.	-2000
Off	1011	30. Neme end addres	ss of person who co	empleted charse of de	eth (Item	23e) (Type, Pr	int) W. A	Jorth 4	hienne	Bar	40 A	19 2/2/7
	State Registrar	31. Data filed (Month	Day, Year)	32. Registre	r's Signet	ure	1					



State of Maryland / Department of Health and Mental Hygiene

						Cert	ificate of	Death			Reg. No.	3 6	9483
		1. Decedent's Name (First,	Middle, Las	t)	THE STATE OF					2. Date of Do		Von	3. Time of Deeth
	Physician (Medical	Kevin Lamont	Thom	as. Sr.						July	21	2000	6:30 A.M.
	. /Medical Examiner	4e Facility Name (If not insi			er)			4b. City, To	own, or Lo	ocation of Deal	h 4c. Count	ty of Death	T O SO CALL
4	Cxammer									20	N/A		
1	Superal	5. Social Security Number	6. Se		Age (In yrs. last bi	irthday)	If Under 1 Yeer	If Under	timo:	8. Dete of Bi	rth		place (State or Foreign
ш	Funeral Director	218-74-0222	1	□ M 2□ F	42	Yrs.	Months Days	Hours	Min.	06/1/	Dete of Birth (Month, Day, Year) 06/14/1958  9. Birthplace (State or Country) MD		
ш		Usual Residence of Decede	ent		42					1 00/14/1330   110			
	Par de la	10a. State 10b. C	ounty		10c. City, Tov	wn or Loca	ation				Od. Inside City Limits		
	dary de t	MD N	/ A		Dol+:	mana							1 Yes 2 No
	vith the Mar t or 28s-f e be notified Director	MD N/	A		Balti	more	10f. Zip Code				10g. Citizen of	What Cour	ntry?
	The Page 10											Wilat Cour	my i
	death with the Maryland one 23e or 28e-f show Linual be notified at neral Director	3400 Woodlar	nd Ave				21215			W 14	USA		
	ges 1 and 2 should be filed within 72 hours efter death with the Mandart of Health and Mental Hygiene. If Ham 27 is marked other than "natural", or itema 23s or 28s-f show or other traumatic avent, the Medical Examinar must be notified at or other Touresto Director.  To Be Completed by Funeral Director.	11. Merital Stetus		12. Wes Decede Armed Force	s?	13. W	as Decedent of Yes, specify Cut	an, Mexice	n, Puerto	Rican, etc.)	0- 14. Ha	ace - Americ ack, White,	
50	S S S			1 Tes 2		10	Yes 2 No	Specify	:		Speci	ity: Bla	ck
21215-0020	72 hours effer netural; or to a rel Examinal	3 Widowed 4 Div	orced	Year or Dete	s:					S			·
5	ed within 72 ho ygiene. Wer than "natural, the the call Completed	15. Dec	edent's Ed		168	(Give k	ent's Usuel Occu ind of work done	during mos	st of work	in <i>g</i>	16b. Kind of I	Business/Inc	dustry
21	within one.	Elementery/Secondary (0	1	College (1-4d	or 5+)	life. Do	O NOT use retire	ed)					
	Hygier the end, the Cor	12th				Disa	bled				N/A		
pu	Be Be	17. Father's Name (First, M.	iddle, Last)					18. Moth	er's Nami	e (First, Middle	, Maiden Suma	me)	
/ja	build be filled with Mental Hygiene. Britch other than attc avent, the To Be Comp	Ernest Thoma	as					Sh	irle	Masor			
Maryland	2 should and Mer is marks aumatic	19a. Informant's Name/Rei		ype, Print)	19	b. Mailing	Address (Stree					n, Stete, Zip	Code)
	and 2 patth a n 27 is er tra	Glyndora The	mae/s	Sietor		3/10	00 Woodl	and A	770	Raltin	ore M	212	15
e,	Health Health Lam 27 other tr	20e. Method of Disposition	MIGS/ L	ISLEL	20b. Place	of Disposi	ition (Name of		VCap	Date	20c. Location		
0	Pages nent of int: If it iny or o	1 Buriai 2 Crema			te cemete	ery, creme	atory or other pla	ica)					
Ħ	Tame Nun	4 Donation & Oth	£	-	Mt.	Zic	n Cemet Name and Addr	ery	0	7/28/00	Lans	downe	., MD
Baltimore,	permit. Pages 1 and Department of Health Important: If Itam 27 any Injury or other tr onca.	21. Signature of Funeral Se	/ /	UL	- /	7	Charria	Funor	al L	ome P.	A. 200	7-09	Eastern Av.
	40240	23a. Part Enter the disea shoot, or heart failus	ey (	Man	uff.		Baltimo	re. M	D 2	1231 -	(410) 3	342-74	00
1	SOUND BY	23a. Part Enter the disease shock or heart failure	e or comp	olications that cause on each	sed the death. Do	not enter	the mode of dy	ing, such as	s cardiec	or respiretory	errest,		Approximate Interval Between
	Physician	1000		/									Onset and Death
4	/Medical	Immediate Cause (Final disease or condition		T 1 0:	ATDC							1	
П	Examiner	resulting in death)		e End Sta	age AIDS Due to (or as a	0000000	onno oth					- 1	
ш	<u> </u>	The sales			Due to (or as a	consequ	ierice ory.					1	
	axecuted in and lateransit	The second second		b	0 - 4- 4							1	
	certificate be assecuted nding physician and use as the burlal-transit	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury			Due to (or as a	consequ	ence of):						
9	be a buri	Cause (Disease or injury	~	C									
68760,	ficata be physicial is the bu	thet initieted events resulting in death) Last			Due to (or as a	conseque	enca of):						
9 x	M S	T Pt 6		d									
Box	attendi I for us		_	<b>V.</b>								Ì	
	0 0 0	Part II. Other significant co	nditions co	entributing to deat	h but not resulting	in the und	derlying cause g	iven in Part	1.	23b. Dtc	tobacco use c	ontribute	o the cause of deeth?
P.0	ed by the detached									10	Yes 2 10	3 □ Pro	bably 4 Unknown
	= 00							-				7	
Records,	een sign hould be									24a. We	s an autopsy	24b. W	ere autopsy findings
00	been s should									pen	ormed?	CO	ompletion of cause death?
Re	The lew requir												
	cate he	The Action of the Control		The same of						1	Yes 2 No	11	☐ Yes 2☐ No
Vital	certificate rector, pag	25. Was case referred to mexaminer?	-	Hospital:			10		e of Deet	h (Check only	one)		
of	Y SO P	1 Yes 2 110		1 Minp			3LI DOA		ursing Ho		idenca 6 □O		(y)
	After the funerel funerel	27. Manner of Death	ending	28a. Date of 1 (Month,	njury Day Year) 28b.	Time of Injury	28c. Inju	rry at ork?		28d. Describe	how injury occi	bernu	
0	Attending or death.  octor: After by the fune fune fill cation	2 Accident in	vestigetion				M 1	Yes 2	No				
Division	after death Director: / J in by the		ould not be etermined	28e. Placa of	Injury - At home, f	arm, stree	et, factory, office			28f. Location City or To	(Street and Nun	nber or Ruri	al Route Number,
ā	tal or Attanding P rs after death. all Directors After ted in by the funer Certification:	- Tomore	,	ounding,	oto. (Specify)					ony on the	vivi, Olato,		
	Hospital 24 hours Funeral stely filled	29a, Certifier 1 Cer	rtifying Phy	rsician: To the be	st of my knowledg	e, death	occurred et the t	ime, date a	nd place,	and due to the	cause(s) and r	nanner es s	stated.
	To the Hospital within 24 hours to the Funeral completely filled	(Check only 2 Me	dical Exam	iner: On the basis and manner	of examination a	nd/or inve	estigation, In my	opinion, de	ath occur	red at the time	, date and place	s, and due to	o the cause(s)
	omp omp	29b. Signature and title of	ejine	10	1		29c. Licen	se number			29d. Dete sign	ned (Month,	Day, Year)
	- STON	1	A	(1)	N	/							
		1	70-	0	7			4266			July	, 21,	2000
	212	30. Name end address of pe	who o										
	(1/4)		01 W		ere Ave.,	Bal	timore,	MD	2121	)			
	State	31. Data filed (Month, Pay	nn i	32. Regi	istrar's Signature	1	all						
	Registrar	011 1 0 70	.00	In my	0.	pp	all						



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Year HILTON TORREYCO 1,25 PM 0 00 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Genesis Eldercare of Randallstown Randallstown Baltimore If Under 1 Year 6. Sex 1 M 2 □ F If Under 24 Hrs. Hours Min. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Yrs. 220-28-5869 69 21,1931Washington, DC Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 Yes 2 No MD Charles Newburg 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 12685 Wicomico Beach Road 20664 USA 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Mechanic Automotive 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Hilton Lewis Torreyson, Sr. Maude Hilda Boswell 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey Young Sister 5849 Fairmont Drive, Redding, CA 96003 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Carroll Cremation 9/18/00 Hampstead, MD of Funeral Service Licens 22. Name end Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death SEPSIS Immediate Cause (Finel disease or condition resulting in deeth) PNEUMOR Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last Due to (or as e consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No 24b. Were eutopsy findings available prior to 24a. Wes en eutopsy performed? completion of cause of deeth? MFECTION 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Neture 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Examiner burial-transit The law requires that the death certificate be executed and Division of Vital Records. P.O. Box 68760. attending physician the signed by t Deed certificata

Examiner Physician/Medical þ Completed Be Medical Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show must be notified at

hems 23a or

"natural", or

permit. Pages 1 and 2 should be filed within Department of Mealth and Mental Hygines Important: If hem 27 Is marked other than any Injury or other traumatic avantages.

**Physician** 

/Medical

the Medical Examiner

Director

Funeral

þ

Completed

Be

the Maryland

72 hours after

Baltimore, Maryland 21215-0020

Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifica within 24 hours after de To the Funeral Directo completely filled in by th

e E 0

**DHMH 16 Rev 6/95** 

State Registrar

31. Dete filed (Month, Day, Year) SEP 1 9 2000

29b. Signeture and title of certifier

29s. Certifier (Check only one)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREZNE

ins

(127

**ORIGINAL** 

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated.

RD,

29c. License number

DS2360

KUUSIR SANDHU

SU172 300

29d. Date signed (Month, Day, Year)

PIICESVILLE

NUS

21208

abeth L.	Valentine	re Legi ene		29485						
				Ce	rtificate of	Death	,	, No.		
	Decedeni'a Name (Fire	st, Middle, Last)					2. Date of Deeth		Veer	3. Time oi Death
Physician /Medical		Eliza	beth	Louise V	alentine		Septembe	er 14,	2000	2015 pm
Examiner	4a Facility Name (If not	institution, give street and	number)			4b. City, Town, or I	ocation of Deeth	4c. County	oi Death	
	6614 Eberle	Drive, Apa	rtment	t #103		Baltimon	re	N/A		
Funoral	5. Social Security Number		7. Age	(In yrs. last birthday)	If Under 1 Yes	r If Under 24 Hrs.	8. Dete of Birth		9. Birthpli	ace (Stete or Foreign

Director

the Maryland 280-11 8 Examiner must be Nems 23s Pages 1 and 2 should be fried within 72 hours after ò 'natural'. other than "r ent, the Med is marked other I Health and Mental them 27 is marked o To ò

늄 Funeral P. Completed

Department of Important: If It

Baltimore, Maryland 21215-0020 Physician /Medical Examiner

The law requires that the death certificate be asscuted attending physician and for use es the burial-transit ed by the a signed by t should I page 2 s has certificate or Attending Physician: this After t Hospital

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner Completed by Be Certification: To

27. Manner of Death 2 Accident 3 Suicide 4 Homicide

124 hours after death. Funeral Director: Aft pletely filled in by the fur 29a. Certifier edicai (Check only one) within 2 the 3 29b. Signature and title of certif 30. Name and address of person who completed or

Mary

State Registrar

G. Ripple, M.D. 31. Date iiled (Month, Dey, Year) 1 9 2000 SEP

32 Registrar's Signature

28e. Place of Injury - At home, iarm, street, lactory, office building, etc. (Specify)

deeth (Item 23a) (Type, Print)

Days Hours 1 M 2 C)(F 62 Yrs. 2-21-1938 219-34-0650 S.C. Usuat Residence of Decedent 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Q Yes 2 □ No Md N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 6614 Eberle Drive Apt 103 21215 12. Was Decedent Ever in U,S Armed Forces? Was Decedeni of Hispanic Origin? (Specify Yea or No II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify **Black** 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) N/A Hospital Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Samuel Solley Valentine Ruth Lee Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Victor Gwaltney- Brother 3105 Betlou James Place Baltimore, Md 21207 20b. Piace of Disposition (Neme of cemetery, crematory or other plece) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 Cremation 3 Removal from State King Memorial Park 9-20-00 Randallstown, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart hiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseasa or condition resulting In death) Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury thai initiated events resulting in death) Last Due to (or as a consequenca of) Due to (or as a consequence oi) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably → Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24e. Was an autopsy performed? Inspection 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

16. Yes 2 No 26. Place oi Death (Check only one) Hospital: Other:  $_{4}\square$  Nursing Home  $_{5}\square$  Residence (MOther (Specify) at SCENE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Dascribe how injury occurred 5 Pending investigation 1 Yes 2 No 6 Could not be determined

28f. Location (Street end Number or Rurel Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

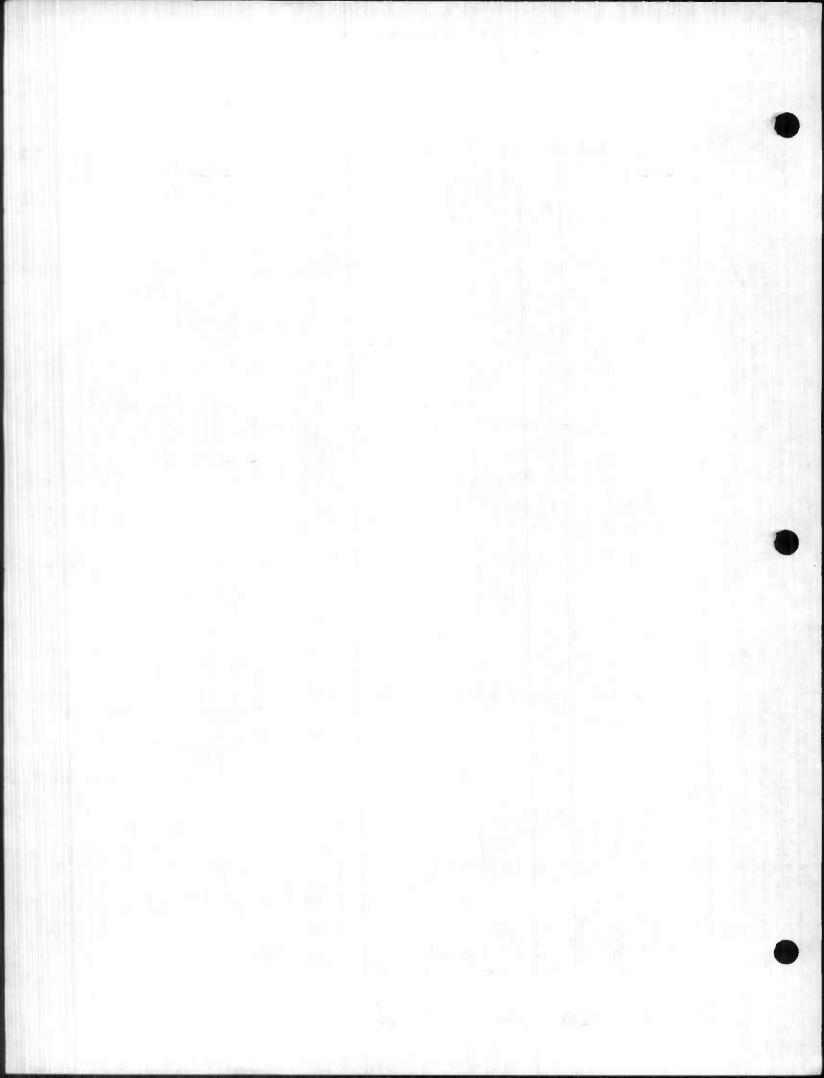
29d. Date signed (Month, Dey, Year)

September 15, 2000

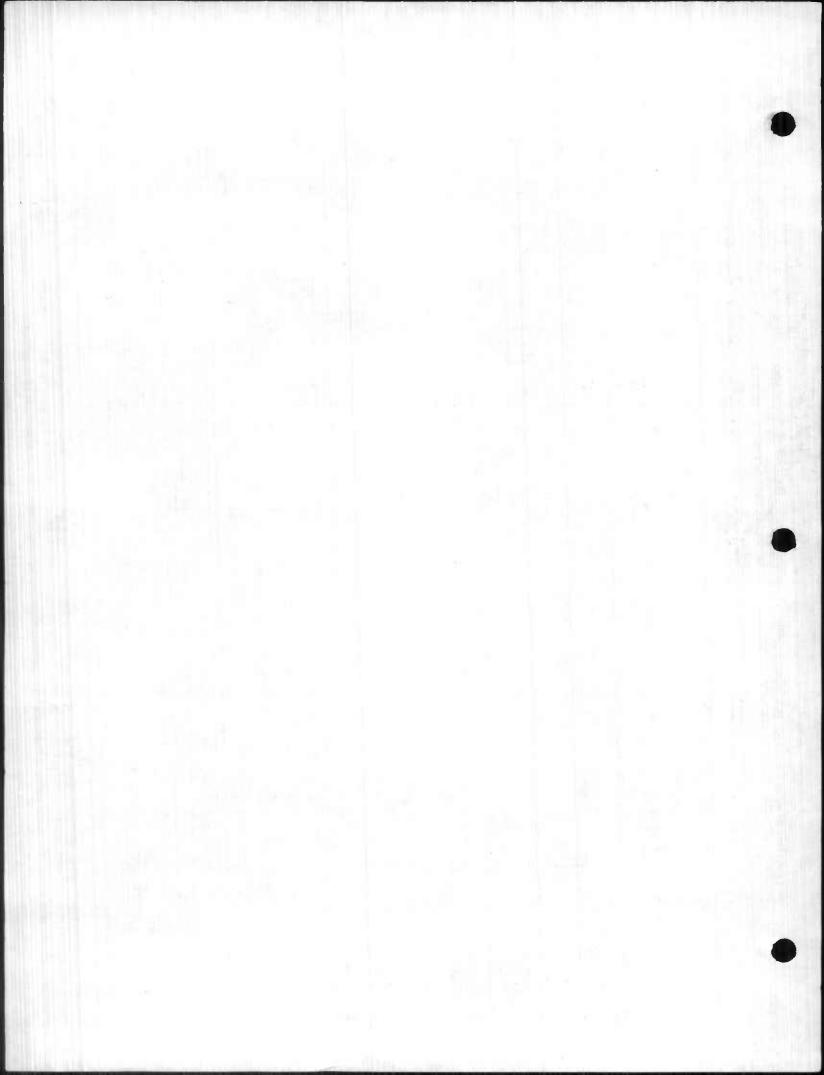
111 Penn Street, Baltimore, Maryland 21201

29c. License number

O.C.M.E.



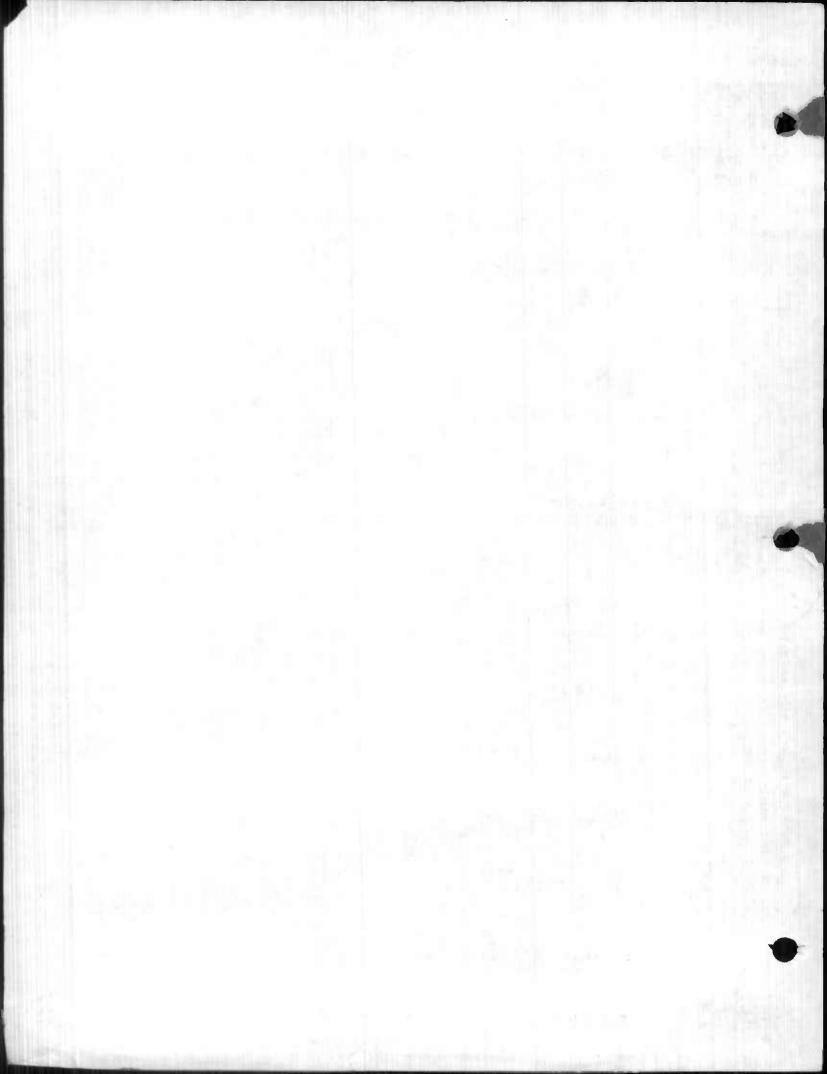
ORIGINAL



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Immediate Cause (Final disease or condition resulting in death)  INTRACEREBRAL HEMORRHAGE DUE TO HYPERTENSIVE ATHEROSLCEROTIC CARDIOVASCULAR DISEASE  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):															
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ntially list conditions, leading to immediate . Enter Underlying	Du	ue to (or	as a consaqu	ence of):											
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Other significant conditions	contributing to death but r	not result	ting in the und	derlying ca	ause give	en in Part I.	23b. Did	tobecco use co	ntribute to the c	ause of death					
							1 🗆	Yes 2 No	3 Probably	4 Unknow					
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	28a. Date of Injury (Month, Day Y	(ear)		28	Bc. Injury Work	y at k?	28d. Describe	how injury occur	red						
2 Accident Investigation M 1 Yes 2															
	28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)						28f. Location ( City or To	(Street and Numb wn, Stete)	ber or Rural Rout	Number,					
29a. Cartifier  (Check only 20 Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner as stated.															
check only 2 Medical Exa	miner: On the basis of ex	A	DIT GITTE OF 11110						od (Month Day V	ear)					
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State Registrar

31. Date filed (Month, Day, Year) 32. Fil



State of Maryland / Department of Health and Mental Hygiene

29488 Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** September 1, 2000 9:30 PM Jennifer Drayton Austin /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** 8606 Barron Street Takoma Park Montgomery If Under 24 Hrs.
Hours Min.

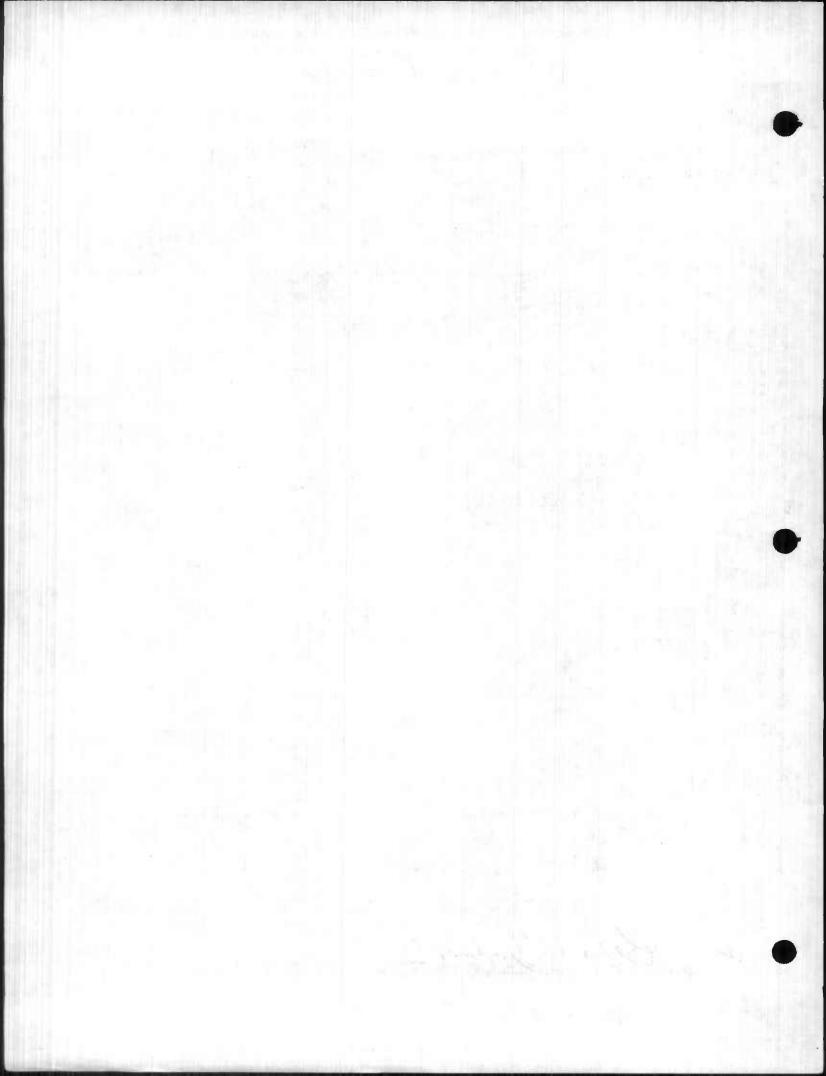
8. Dete of Birth
(Month, Day, Year)
Jan. 8, 19 If Under 1 Yeer 9. Birthplace (State or Foreign Country) Maryland 5. Sociel Security Number 7. Age (In yrs. lest birthdey) **Funeral** Months Days 1□M 2\ F 36 Yrs 1964 219-52-6242 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 23s or 28s-f show 1√2 Yes 2 □ No Directo Maryland Prince Georges Hyattsville 10e. Street and Number 10g, Citizen of What Country? 10f. Zio Code United States 2006 Tuckerman Street 20782 Funeral 14. Race - American Indian, Black, White, etc. or flema 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Merital Status 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify: Black h 3 Widowed 4 Divorced filed within 72 hours. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) 5+ Self Employed Anthropologist 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) . Pages 1 and 2 should be fit thent of Health and Mental H tarit. If them 27 is marked off dury or other traumatic even Be Catherine Dawson Elmont Billy Drayton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 Ginger Bend Dr. #106, Champaign, IL 61822 Nigel W. Austin Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 ABurial 2 Cremation 3 Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) George Washington 9/8/00 Adelphi, Maryland 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signatuse of Funeral Service Licentee 7400 Georgia Ave. N.W., Washington, D.C. 20012 Approximete Interval Between Onset and Death 23a. Part. Enter the disease, opcomplications that caused shock, or heart failure. List only one cause on each light e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medical Acute Respiratory Failure 14 days Examiner Due to (or as a consequence of) Physician/Medical Examiner 12 months Metastatic Carcinoma of the Breast The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or es a consequence of): Due to (or es e consequenca of) 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? detached 100 1 Yes 2 No 3 Probably 4 Unknown 2 by 2 should be 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed certificate has Boed 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Nother (Specify) house Certification: To 1 Yes 2 No this 28c. tnjury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Deacribe how injury occurred After Division 1 X Watural 5 Panding Injury after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) 29b. Signature and file of certifier 29c. License number 29d. Date signed (Month, Day, Year) DC 20182 September 2, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1160 Varnum Street, N.E. #214 Washington, D.C. 20017 Leslie Kingslow, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State souls

**DHMH 16 Rev 6/95** 

Registrar

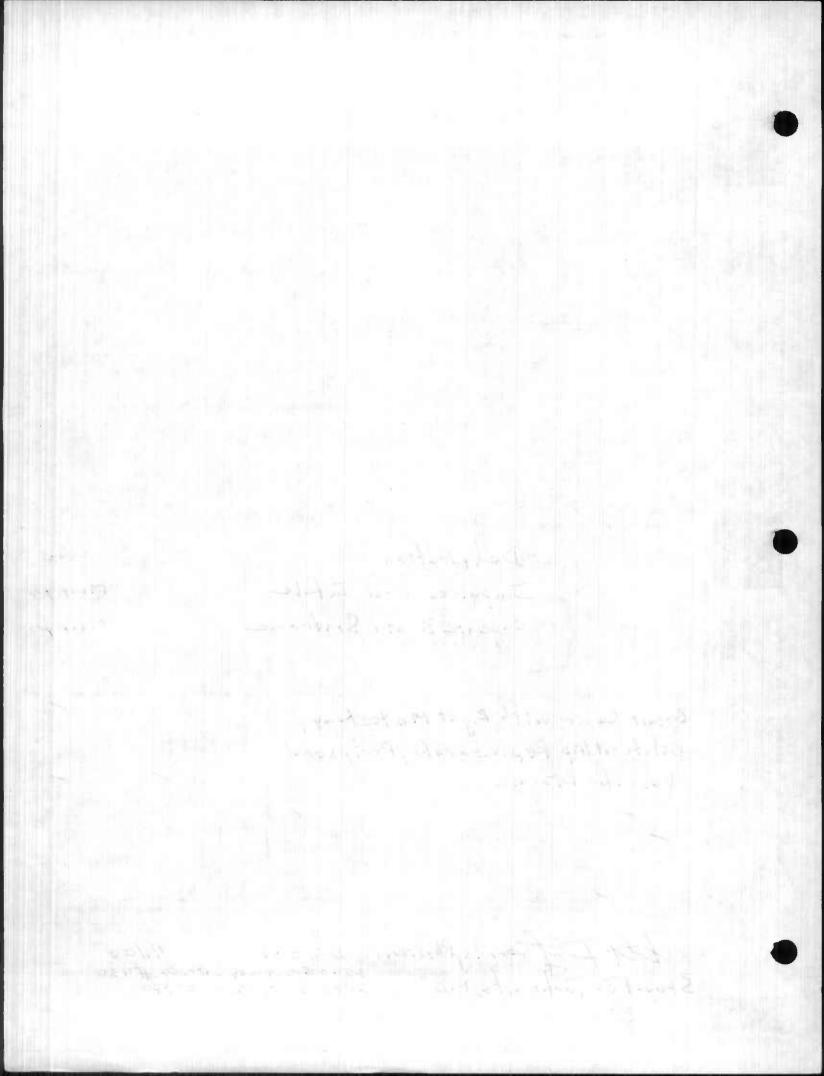
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Box 68760, P.O. of Vital Records,



State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** MARY C. ANTONELLI 4, 2000 th 4c. County of Death SEPT 10:05 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 829 Ivy League Lane Rockville MONTGOMERY H Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct. 15, 1917 If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 10M 20F 136-12-2065 82 New Jersey Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or itams 23s or 25s-f show MD Montgomery 10 Yes 2 No Rockville Director 10a Street and Number 10f Zin Code 10g. Citizen of What Country? 829 Ivy League Lane 20850 U.S.A. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? t Never Merried 2 Merried 1 Yes 2 No If Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 5 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working tile. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) 12th College (1-4or 5+) permit. Pages 1 and 2 should be filled in Department of Health and Mental Hygien important: if Nem 27 is marked other the any Injury or other traumatic and other than 2006. Self Seamstress 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) 86 Luigi Labrunda Rosa Ridolfo 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurat Route Number, City or Town, Stata, Zip Code) Rocco Antonelli (Son) 829 Ivv League Lane, Rockville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from State Metropolitan f/Serv 9/5/00 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensu 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feithin. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Examiner Examiner Diverticulitis physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760 Diabetes Mellitis Physician/Medical Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? P.0. á 1 Yes 2 No 3 Probably 4 Unknown Hypertension, Alzheimer's Disease signed to Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? peen Polymyalgia Rheumatica; Chronic Renal 1 Yes 2 No 1 ☐ Yes 2 ☐ No Failure Division of Vital 25. Wes case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yas 2⊠ No this in 24 hours after death.

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State

Registrar

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615 W. Montgomery Ave., Rockville, MD

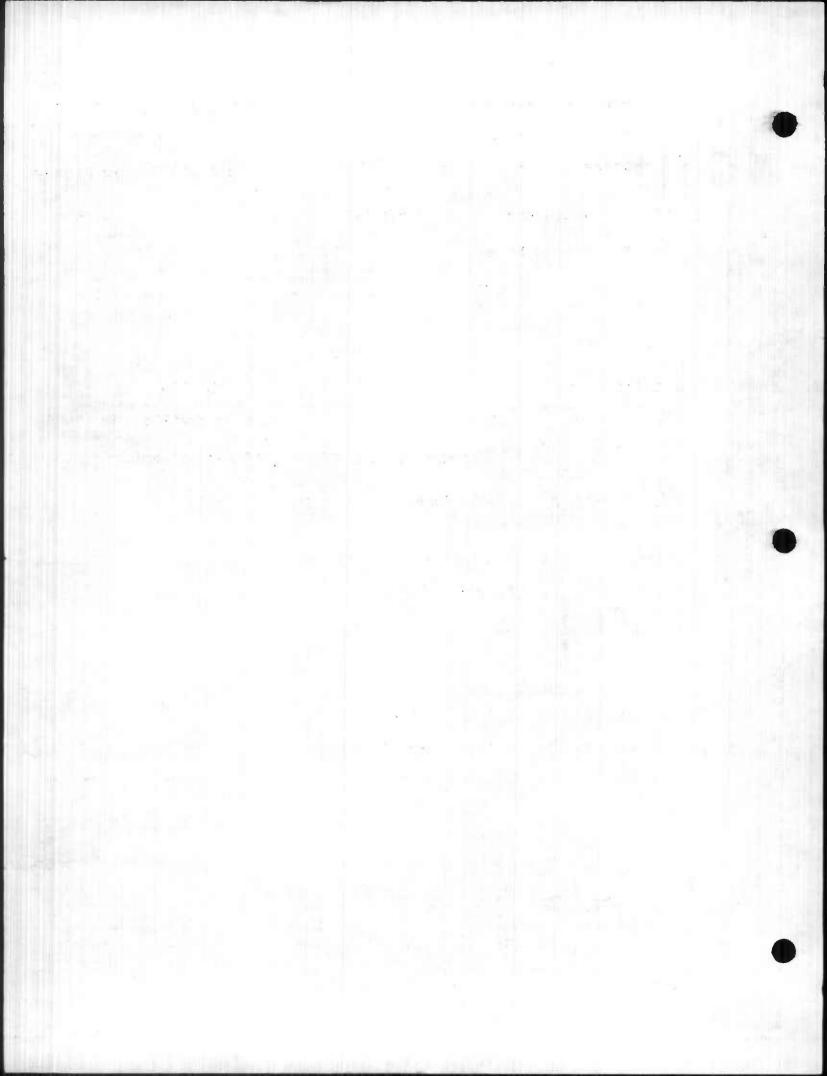
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Douglas R. Shumaker, M.D.

31. Dete filed (Month, Day, Year)

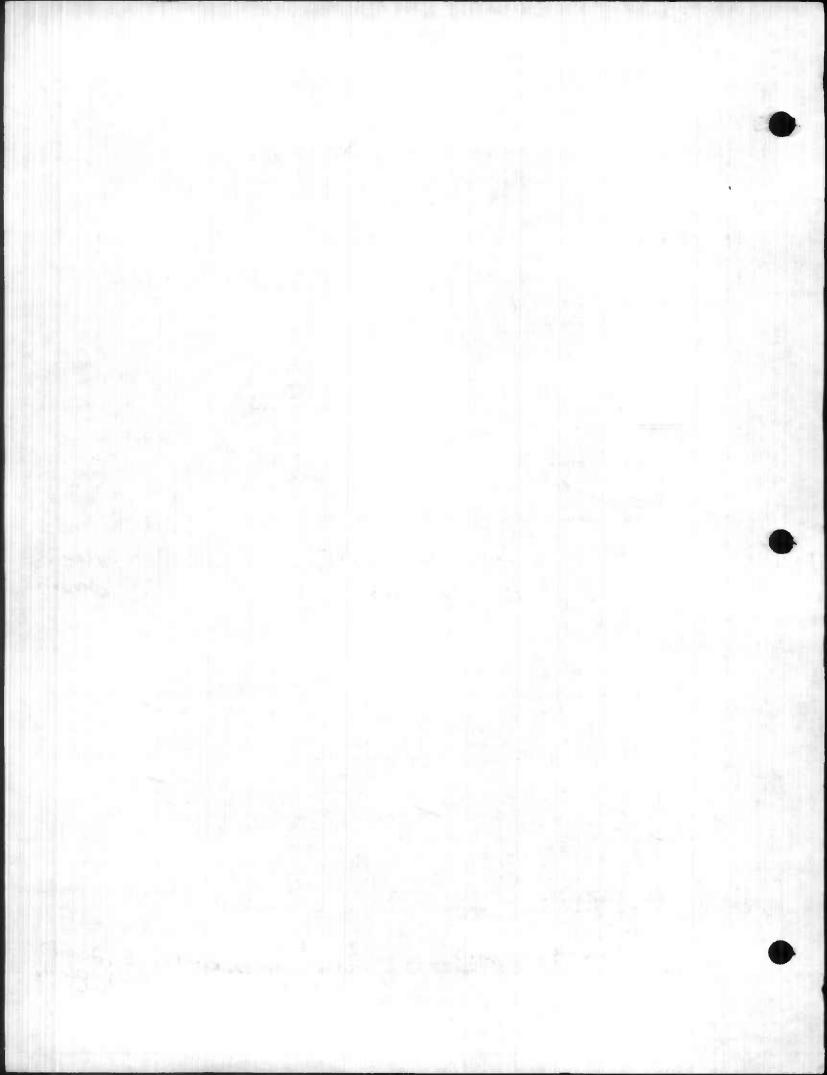
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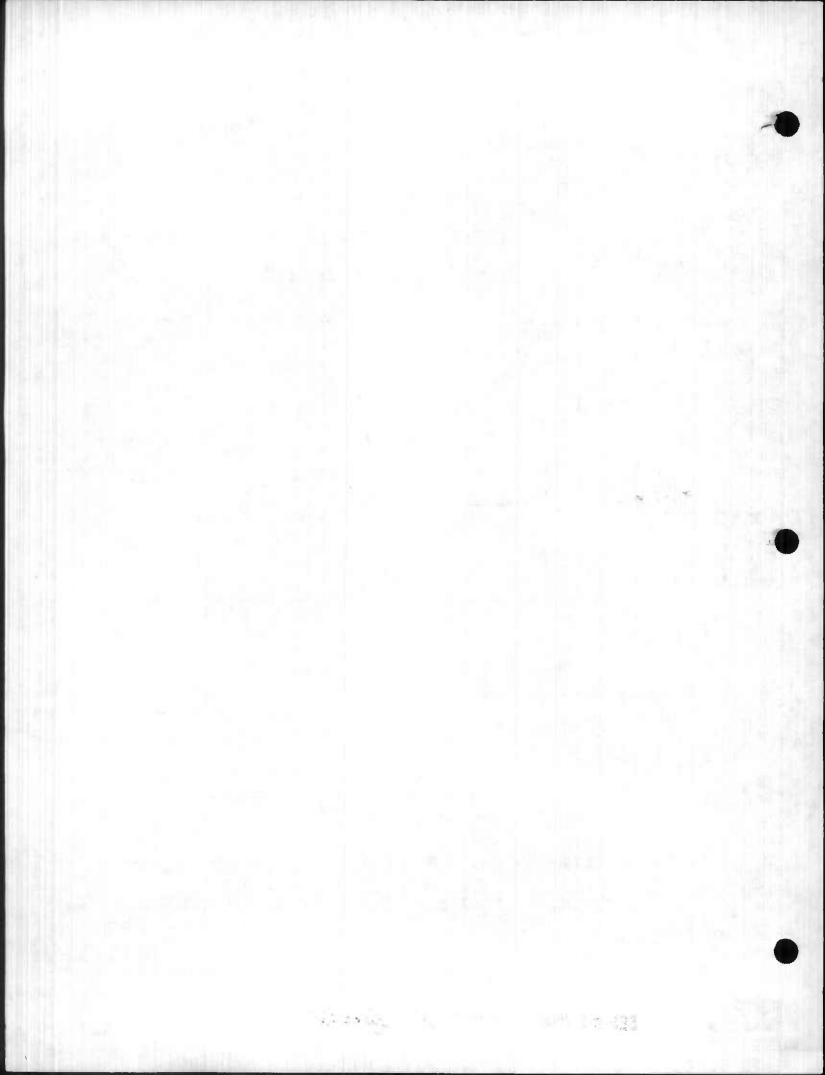
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Vital Records,	faw requires that the as been signed by the 2 should be detache	Completed									s an autopsy formed?	24b. Were autopsy findings available prior to completion of ceuse of death?
Re	The law ate has page 2	E								10	Yes 2 ₩ No	1 Yes 2 No
ta	ician: Th certificate rector, par	Pe C	25. Was case refer	red to medical					26. Place of Dea		Non-	
>		2	examiner?	No	Hospital:	patient 2	ER/Outpati	ent 3 DOA Ot	her:		sidence 6 Othe	or (Specify)
	ding Phys h. After this funeral d		27. Manner of Deat		28a. Date of	Injury Day Year)	28b. Time		ry at	28d. Describe	how injury occurr	ed
ioi	Attending or death. ector: After by the fune	atic	1 Accident	5 Pending investigation	on	, , , , , , ,			Yes 2□No			
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	289. Place	of Injury - At hig, etc. (Specif	ome, farm, :	street, factory, office		28f. Location City or To	(Street and Number own, State)	er or Rural Route Number,
	Hospital or 24 hours afte Funeral Dir stely filled in	a C	29a. Certifier	1 Certifying Pl	hysician: To the b	est of my kno	wledge, de	ath occurred at the ti	me, date and place	, and due to the	e cause(s) and ma	nner as stated
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	(Check only one)			sis of examina						and due to the cause(s)
	within 2 To the comple	Σ	29b. Signature and	title of certifier				29c. Licen:				(Month, Day, Year)
	10		MAI	mark	L.	CIN		53	177		SOPT	6.2000
	(30)	)	30. Name and address	ess of person who	completed cause	of death (Item	1 23a) (Typ	e, Print) 3040	7 Modi	CAL (e)	YEOUS DA	6,2000 2. Rockille
P	Stat Registra	_	31. Date tiled (Moni		0000 10	gistrar's Signa	iture 4	Look	h			

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

			Certi	ficate of	Death		Reg. No.	0 6	9496		
Dharainian	1. Decedent's Neme (First, Middle, Las					2. Dete of De Month	-	Year	3. Tima of Death		
Physician / Medical	Elizabeth T. Avel	.la				August	28°, 2	d <b>0</b> 0	8:23 pm		
Examiner	4a Facility Nama (If not institution, give	street end number)			4b. City, Town, or	Location of Deet	4c. County	of Death			
	Anne Arundel Medi				Annapo	lis	Anne	Arund			
Funeral Director	091-40-7700	9x 7. Age (In yrs. □ M 20XF 52	A	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		4, 1948	9. Birthple Country New Y	oce (State or Foreign Y) YORK		
pu ku	Usuel Residence of Decedent  10a, Stete 10b, County	10c. Cit	ty, Town or Locat	tion				10	d. Inside City Limits		
with the Maryland a or 28a-1 show the notified at Director	MD Anne Aru	undel A	nnapolis						1 ☐ Yes 2X No		
ar death with the Maryla thems 23a or 28a-1 show ther must be notified at unnersi Director	10e. Street and Number 608 Edwards Road			21401			10g. Citizen of V USA				
by F	11. Meritel Status  1 Never Married 2 Merried  3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Yeer or Detes:		s Decedent of I es, specify Cub Yes 28 No		Specify Yes or No rto Rican, etc.)	Blec	e - American k, White, et Whit	tc.		
ed within 72 ho ygiens. we then "natur t, the Medical. Completed	15. Decedent's Ed (Specify only highest gra-	ucetion de completed)	16a. Deceden (Give kin	it's Usuel Occu	petion during most of wid)	orking	16b. Kind of Bu	siness/Indu	istry		
the Me	Elementery/Secondary (0-12)	College (1-4or 5+)		onor use retire			Law F	irm			
O Mend	17. Father's Neme (First, Middle, Last)	4			•	eme (First, Middle					
id be for the series of the se	Edward Eberhardt				Eliza	beth Eber	rhardt				
and Manual Manua	19e. Informant's Neme/Relationship (7	Type, Print)	19b. Mailing	Address (Stree	t end Number or F	Rurel Route Numb	er, City or Town,	State, Zip C	Code)		
C = 00 b	Edward Eberhardt/	Father	113 We	st Bayv	iew Driv	e, Laval	ette, N	087	735		
mit. Pages 1 a partiment of Hei portant; if Item y Injury or othe	20e. Method of Disposition  1 Buriel 2 Cremetion 3 4 Donation 5 Other (Special	Hemoval from State	ion (Name of tory or other pla natory	ce)	Aug 30 2000	20c. Locetion - Baltim					
paemit. Departi Importu any inj ance	21. Signature of General Service Liceo	200	Bar	ranco a	Sons, I Ritchie	P.A. Ser	verna Pa verna Pa	rk Fu	neral Home		
	23a. P. W. Enter the disease, or comp.	olications that caused the deat							Approximete Interval Between		
Physician /Medical	Immediate Cause (Final disease or condition		0	muri					Onset end Deeth		
Examiner 6	resulting in death)	Due to (or es a consequence of):									
axecuted in and ial-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Undertying Cause (Disease or Injury	b. Due to (c		1							
ng physicia as the bur Aedical	ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last		or es e consequei	nce of):							
at the death cert d by the attendin etached for use Physician/M		d	777117								
	Pert II. Other significant conditions co	ontributing to death but not res	sulting in the unde	erlying ceuse gi	ven in Pert I.	23b. Did	tobacco use co	ntribute to f	the cause of death?		
requires that the de tools signed by the should be detached eted by Physic	Askoutoma				1/2	10	Yes 25 No	3 Probe	ably 4 ☐ Unknown		
							an eutopsy ormed?	avei	re eutopsy findings ilable prior to apletion of cause eath?		
sician: The law certificate hes lirector, page 2 o Be Comp						10	Yes 2000	10	Yes 2 No		
certificate rector, pag	25. Wes case referred to medical exeminer?					eeth (Check only	one)				
7 00	1 Yes 2500	Hospitel: 1 ☐ Inpatient	ER/Outpetlent	3LI DOM		Home 5 Res	idence 6 Oth	er (Specity)	)		
B 5 5 0	27. Menner of Death  1 Staturel 5 Pending 2 Accident investigation		28b. Time of Injury	M 1	ny at ork? ]Yes 2 ☐ No	28d. Describe	how injury occur	red .			
A Voca	3 Suicide 6 Could not be determined	Street end Numb wn, Stete)	er or Rural	Route Number,							
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert	29e. Certifier 15 Certifying Phy (Check only one) 2 Medical Exam	/alcian: To the best of my knowliner: On the basis of examine end menner steled.	owledge, deeth or etion end/or inves	ccurred et the t	ime, dete end ple opinion, death oc	ce, end due to the curred at the time,	cause(s) and ma dete end place,	inner as sta and dua to	ited. the ceuse(s)		
Neithin Me	29b. Signeture and title of certifier				se number		29d. Date signe				
- > - 0	13 ) dan	cm		D37020 8/59/3000							
	30. Nema and address of person who of	completed ceuse of deeth (Iter	P, V V	to Or	in L	herter.	MJ 2	161	9		
State	31. Date filed (Month, Day, Year)	32 Registrer's Signo	eture 4	1	11						



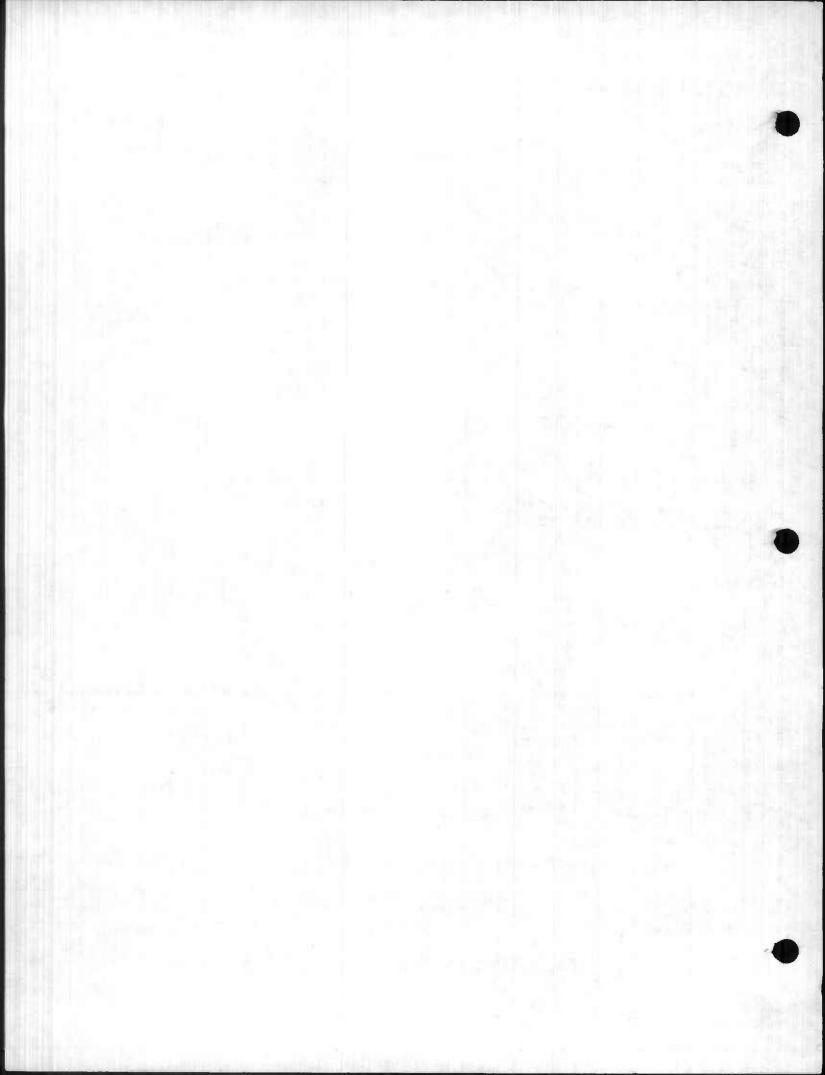
	Decedent's Name (First, Middle, La	et)	Maryland /	Cer	tificate of	Death	2. Date of D	Reg. No.	3. Time of Death
cian	Sterling J.	Burges					Month	Dey	Year
dical	4e Facility Neme (If not institution, giv					4b. City, Town,	Septem or Location of Dee		
iner	Asbury Methodis						ersburg		tgomery
	5. Social Security Number 6. S		Age (In yrs. last I	birthdey)	If Under 1 Yeer	If Under 24 l	rs. 8. Dete of Bi	rth	Birthplace (State or Foreig Country)
	577-10-0321	M 2□ F	89	Yrs.	Months Days	Hours N	March	3, 1911	Washington, DO
- I-	Usuel Residence of Decedent								
	10a. State 10b. County		10c. City, To						10d. Inside City Limits 1 ☐ Yes 2 🔯 No
?  -	Maryland Montgo	mery	Gait	hersl					
	10e. Street and Number				10f. Zip Code	7.0		10g. Citizen of V	
-	304 Russell Aven	12. Wes Deceder	at Ever in II S	12 V	208		(Specify Ves or N	USA 14 Bec	A ee - American Indien,
	11. Meritel Stetus  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Force 1 12 Yes 2 1 If Yes, Give Yeer or Deter	s? ] No		Yes, specify Cub		(Specify Yes or N lerto Rican, etc.)	Specify	ck, White, etc.
	15. Decedent's Ed	ducation		a. Deced	lent's Usual Occu	pation	und in a	16b. Kind of Br	usiness/industry
	(Specify only highest gra	College (1-4o	r 5+)	life. E	kind of work done OO NOT use retire	ed)	working		
	12			Data	a Proces				overnment
	17. Father's Neme (First, Middle, Last)					18. Mother's I	Name (First, Middle	e, Maiden Sumeri	ne)
	Albert C. Burges						et Gardne		
	19e. Informent's Name/Reletionship (	• • • • • • • • • • • • • • • • • • • •					Rural Route Numi		
	Bonnie Zager / PO	A			49th Pla sition (Neme of	ce, Col.	lege Park		and 20740 City or Town, Stete
ĺ	20e. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removel from Stei	ceme	tery, crem	netory or other ple				
	4 Donetion 5 Other (Specific		Fort	lam	oln Cre	natory (	09/05/00	Brentwo	ood, Maryland
į	21. Signtiflure of Furniral Service Licer	1500	11.1	22.	Name end Addre	ess of Fecility 19 W Hampsh	lines-kin Lire Aven	aldi Fun ne	neral Home
	2/200	114	- Lug	5	$Silver S_1$	pring, N	faryland	20904	
	Pert1. Enter the disease, or com shock, or heert feilure. List only	one ceuse on each	ed the deeth. De line.	o not ente	er the mode of dy	ing, such es care	diec or respiretory	errest,	Approximete Interval Between Onset end Death
	Immediate Ceuse (Final								0.1307 0.113 304111
	diseese or condition resulting in deeth)	a	pheu						Laass
			Due to (or es	e conseq	uence of):	,			
		b	Due to (or es	M	den	entica			years
	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury		Due to (or es	e conseq	derica or):				
	that initiated events	C	Due to (or es	e consequ	uence of):				
	resulting in deeth) Lest		200 10 (0.00						
		d							
	Part II. Other eignificant conditions o	ontributing to death	but not resulting	in the un	nderlying ceuse gi	iven in Pert I.	23b. Dtd	i tobacco use co	ntributa to the cause of death
							10	Yee 20 No	3 Probably 4 Unknow
							_		1
								s an eutopsy formed?	24b. Wara autopsy findings evaileble prior to completion of cause
									of death?
	all the same of		15 6				1□	Yes 2 No	1 ☐ Yes 2 ☐ No
	25. Was case referred to medical examiner?	8.6			10		Death (Check only	one)	
completely filled in by the funeral director, page 2 should Medical Certification: To Be Completed	1  Yes 2 100	Hospitai:		Outpetien	1 3LI DOA		g Home 5 Res		
	MM 4.4 4 50 11	28a. Dete of Ir (Month, I	o. Time of Injury	M 1	Yes 2 No		how injury occur		
	27. Menner of Deeth  1 Naturel 5 Pending 2 Accident investigation		1				28f. Location	(Street and Numt own, Stete)	ber or Rural Route Number,
	1 Naturel 5 ☐ Pending	e 28e. Piece of I	Injury - At home, etc. (Specify)	farm, stre	eet, factory, office		Ony or 1	Own, Steley	
	Dataturel 2 Accident 3 Suicide 4 Homicide  29e. Certifier  Dataturel 2 Pending investigetion 6 Could not b determined	28e. Piece of building,	etc. (Specify) st of my knowled of examination (	ge, death	occurred et the t	ime, date and pl	ece, and due to the	e ceuse(s) and ma	anner as stated. and due to the ceuse(s)
	Certifying Ph	28e. Piece of building,	etc. (Specify) st of my knowled of examination (	ge, death	occurred et the trestigation, in my	ime, date and pl opinion, death o se number	ece, and due to the	e ceuse(s) and mo date and place, 29d. Dete signe	

DHMH 16 Rev 6/95

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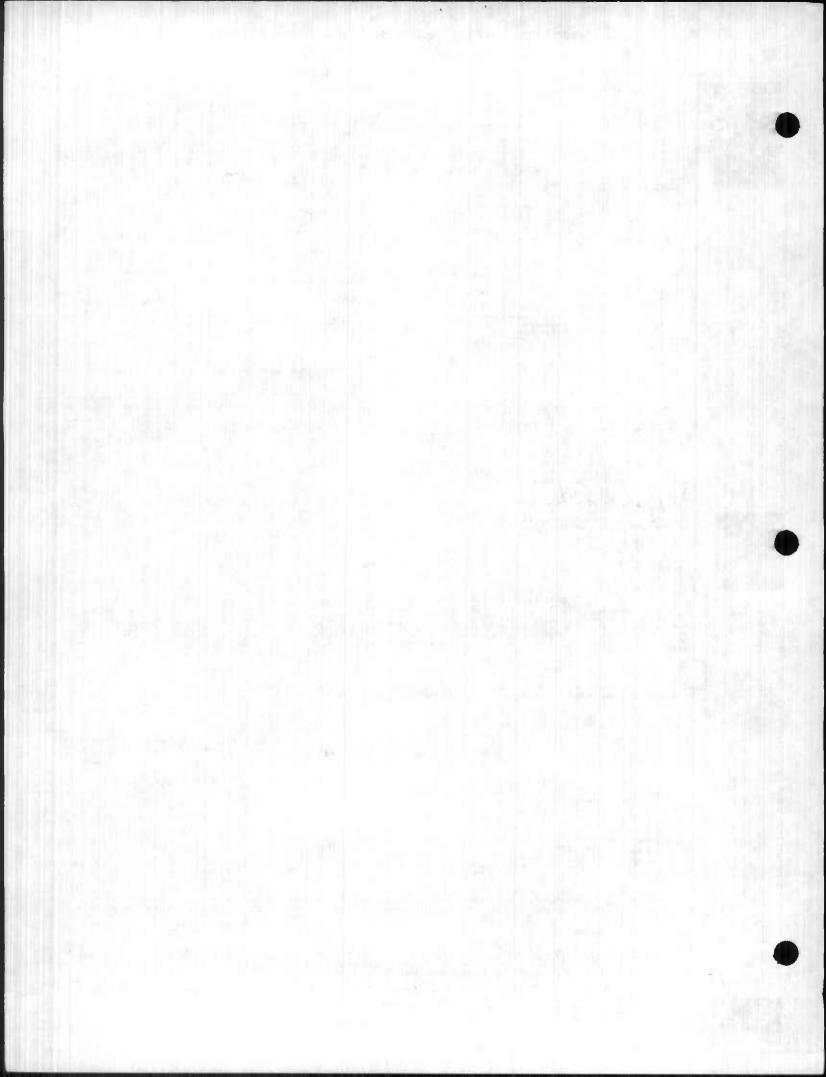
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n al	cedent's Name (First, Middle, La C]											
al	Cl		-	170					<ol><li>Date of De Month</li></ol>	Day	Year	3. Time of Death
4a Fa		arissa Bo		Brenna	ın				Septemb	er 6, 20		11:20 A
	cility Name (If not institution, give	Charles of the Park	100						ation of Deat		y of Death	- 0
5 Sou	Suburban F		e (In yrs. la	st hirthday)	If Under 1	1 Yeer	Bethe		8. Date of Bi		1 tgome	-
578		I□M 2XF	76	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, Di June 2,	1924	Washi	place (State or Foreigntry) ngton, D.C.
10a. S			10c. City,	Town or Lo	cation							10d. Inside City Limit
Ma	ryland Montgo	mery	Bet	thesda	1							1 ☐ Yes 2 N
10e. S	Street and Number 5831 Conway Ro	nad.			10f. Zip (	Code 208	17			10g. Citizen of United		
11 M	arital Status	12. Wes Decedent	Ever in U.S	3. 13.1				gin? (Spec	oify Yes or N			can Indian,
1[	Never Married 2 Married  Widowed 4 Divorced	Armed Forces  1  Yes 2  If Yes, Give Year or Dates:			if Yes, speci 1 ☐ Yes 2		Specify:	, Puerto F	cify Yes or Ni Rican, etc.)	Speci	ack, White, by: W	eic. nite
	15. Decedent's E	ducation		16a Dece	dent's Usual kind of work DO NOT use	Occup	ation	t of working		16b. Kind of I	Business/In	ndustry
Ele	(Specify only highest grammentery/Secondary (0-12)	College (1-4or	5+)				d)	OF WORKE	9			
		4		Hon	nemake	r	40.11	A. II	/e' A.		own Ho	ome
17. Fa	ther's Name (First, Middle, Last									e, Meiden Suma	me)	
10	Joseph Raymond			400 11 00		10:			McHa		- Cr-+: -	n Code)
	Intorment's Name/Relationship (									ber, City or Town		
	Monica B. Smith Method of Disposition	1/Daughter	20b Pis	ace of Dispo	sition (Nam	e of		, KOC	Date	e, Mary]		20852 own, State
1	☐ Buriel 2 ☐ Cremation 3 ☐ ☐ Donation 5 ☐ Other (Specia		Cel	metery, crer	cremat	her plac			eptember 2000			aryland
A	on Tyneral Service Lice	600 4	M0084	RO RO	Neme and	Addre Pu	ss of Facilit	Funer	al Home	e/Bethesda	a-Chevy	7 Chase, Inc
230.	Part // Enter the disease, or com shock, or heart tailure. List only	plication that cause or trause on each I	d the death. ine.								200	Approximate Interval Between Onset and Death
Imme	odiete Cause (Final	a Lung C	22222								1	3 Months
result	ting in death)	a. Lung C.		as a consec	quence ot):							
12.71		h										
Sequifiany	entially list conditions, , leeding to immediate e. Enter Underlying	0.	Due to (or	as a consec	quence of):			- 7			1	
Caus	e. Enter Underlying e (Disease or injury nitiated events	c	D				-				1	
	ing In death) Last		Due to (or	as a conseq	luence ot):							
		0.							not Di			a she source of deat
Parti	Other significant conditions of	contributing to death t	out not resul	iting in the u	nderlying ca	ause gr	ven in Part I					to the cause of deat obably 4 Unkno
		1.16							24a. Wa	s an autopsy formed?	a	Vere eutopsy findings vallable prior to ompletion of cause t death?
									1 🗆	Yes 2 No	1	☐Yes 2☐No
25. W	/as case reterred to medical						26. Place	of Death	(Check only			
a	kaminer? □ Yes 2[X]No	Hospital:	ent 2 E	R/Outpaties	nt 3 DO	A Oth	ner:			sidence 8 🗆 O	ther (Spec	ify)
Composition   Composition								2		how injury occi		
	Suicide 6 Could not be determined	286. Place of in	jury - At hor c. (Specify)	me, farm, str	reet, tactory,	, office		2		(Street and Nun own, Stete)	nber or Rui	ral Route Number,
	Certifier 1 Certifying Processing Check only one)	nysician: To the best miner: On the basis of and manner st	of examinetic	rledge, deetl on and/or in	h occurred a vestigation,	at the tin	me, date an opinion, dea	d place, e	and due to the	e ceuse(s) and r o, date and piece	manner as e, and due	stated. to the cause(s)
-	Signeture end title of certifier	7 .			29c.	Licens	se number			29d. Date sign	ned (Month	, Day, Year)
29b.	a de la companya della companya della companya de la companya dell	/ 11	100	1		D04	766			Septemb	per 7	2000
29b.	Daniel 1	oull	· M	1						D - F III.		, ====

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 3. Tima of Death 2. Date of Death September 05, **Physician** 2000 Bloom. 12:35 pm Ross Frederick Jr /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 90 Waverly Drive, Apt G-304 Frederick Frederick If Under 1 Yeer If Undar 24 Hrs. 5. Social Security Number Data of Birth (Month, Dey, Year) 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 XM 2 F Yrs 579-32-1782 73 June 3, 1927 Maryland Director Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 23s or 28s-f show 1 ☐ Yes 2 No iner must be notified Directo Maryland Frederick Frederick 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Coda 90 Waverly Drive, USA Apt G-304 21702 Funeral 12. Was Decedent Evar in U,S. Armed Forcas?
1 Yas 2 No If Yas, Give Yaar or Datas: 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxicen, Puarto Rican, atc.) 14. Race - American Indian. Black, Whita, atc. filed within 72 hours after 1 Never Merried 2 Married ò Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 5+ Religious Roman Catholic Priest 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) parmit. Pages 1 and 2 should be fill Department of Health and Mental Hy Important: If item 27 is manked oth any injury or other traumatic swen Ross Frederick Bloom Florence Harris 19b. Malling Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Rev. Msgr. Joseph A. Ranieri P.O. Box 29260, Washington, DC 20017 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stete 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Gate of Heaven Cemetery 19/9/00 | Silver Spring, MD 22. Nama and Addrass of Facility. Francis J. Collins Funeral Home, Inc. 21. Signatura of Funaral Sarvice Licenses 500 University Blvd., W, Silver Spring, MD 20901 one that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, nues on each line. 23a. Part1. Enter tha disaasa, or complication shock, or haart failura. List only ona Approximata Interval Between Onset end Death **Physician** Immediata Causa (Final diseasa or condition rasulting in daath) /Medical Ischemic Cardiomyopathy 6 years **Examiner** Dua to (or as a consequence of): Physician/Medical Examiner Coronary Artery Disease 6 years The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadieta causa. Entar Underlying Cause (Diseasa or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Box 68760, Due to (or es e consequance of): 88 980 signed by the a P.0. Part It. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vitai Records, by 24b. Wera autopsy findings available prior to completion of causa of daath? 24e. Wes an autopsy performed? Completed page 1 ☐ Yes 2 No 1 Yes 2 No al or Attending Physician: The safter death.

I Director: After this certificated in by the funerel director, pa Be 25. Was casa rafarrad to medical 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpetlent 3 ☐ DOA Othar: 4 Nursing Homa 5 X Rasidance 6 Othar (Specify) Medical Certification: To 1 Yas 2X No 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how injury occurred Division 5 Pending invastigation 1 Natural 1 Yas 2 No 2 Accidant 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be 3 Suicide 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) filled in by 4 Homicida To the Hospital o within 24 hours af To the Funeral DI Completely filled in 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. Licanse number 29b. Signature and title of certifier D36649 September 05, 2000 15 M 30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print) Edward P. Riuli, M.D., 180 Thomas Johnson Drive, #202, Frederick, Maryland 21702

DHMH 16 Rev 6/95

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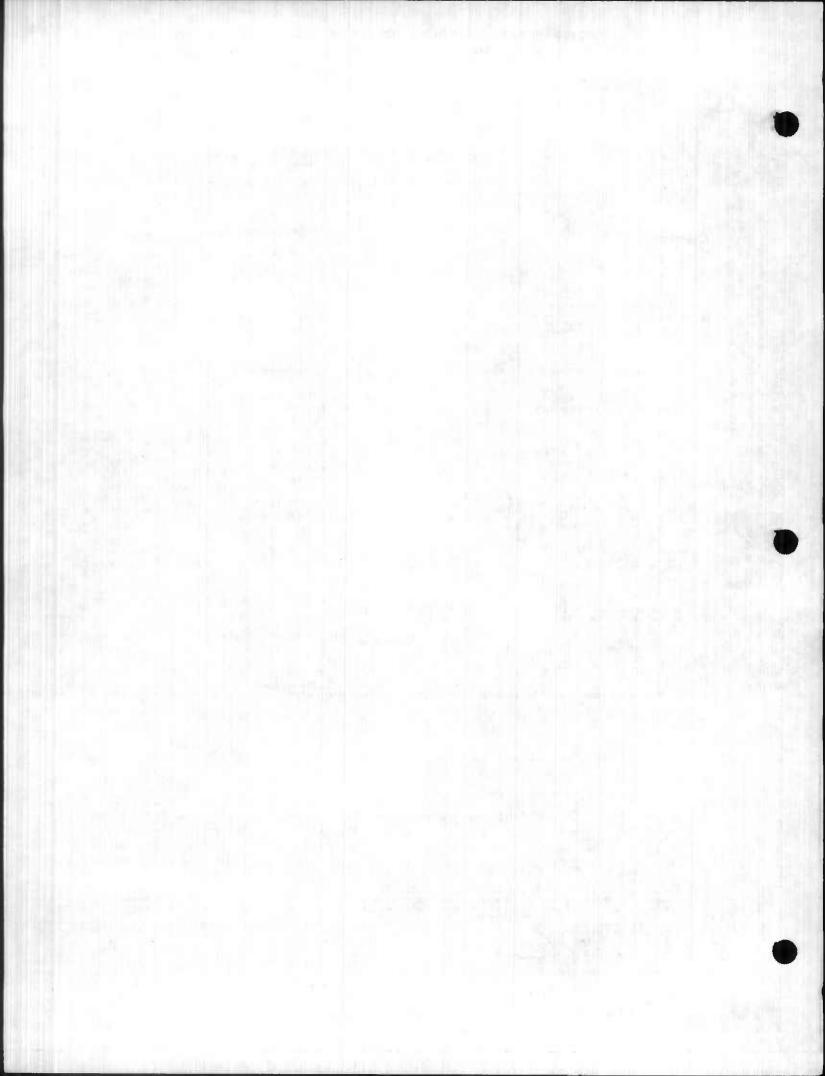
Registrar

31. Dete filed (Month, Day, Year)

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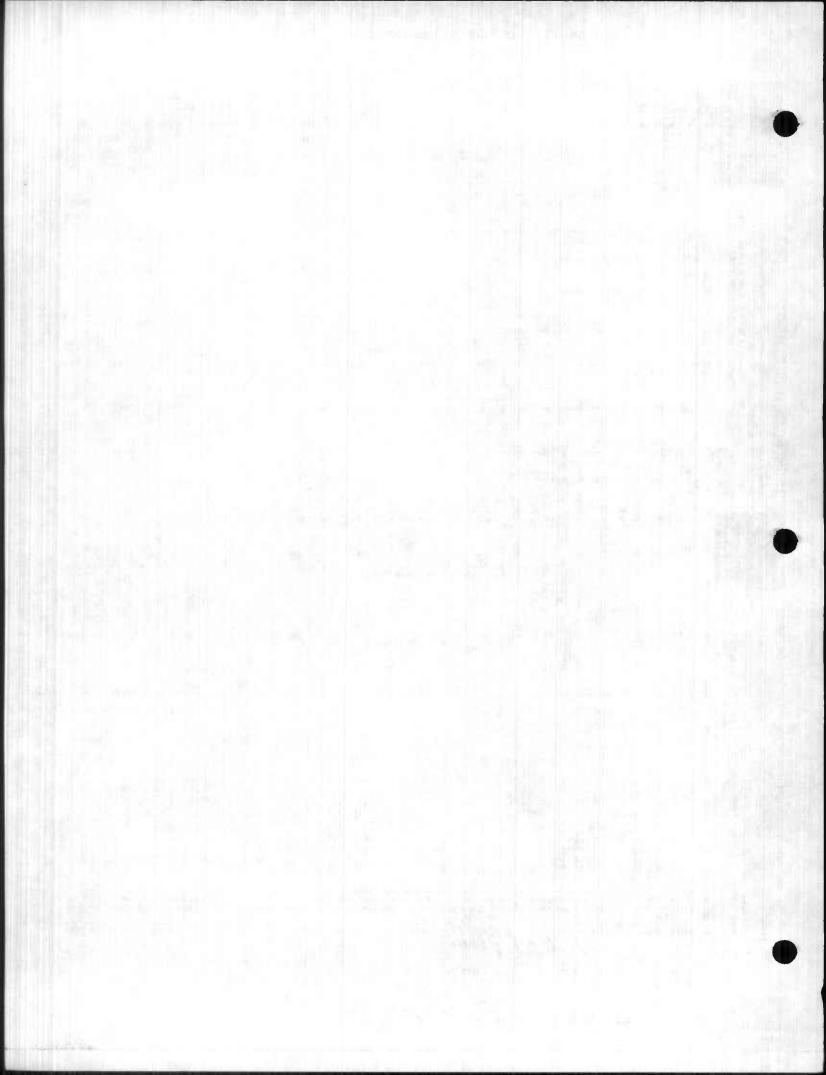
32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

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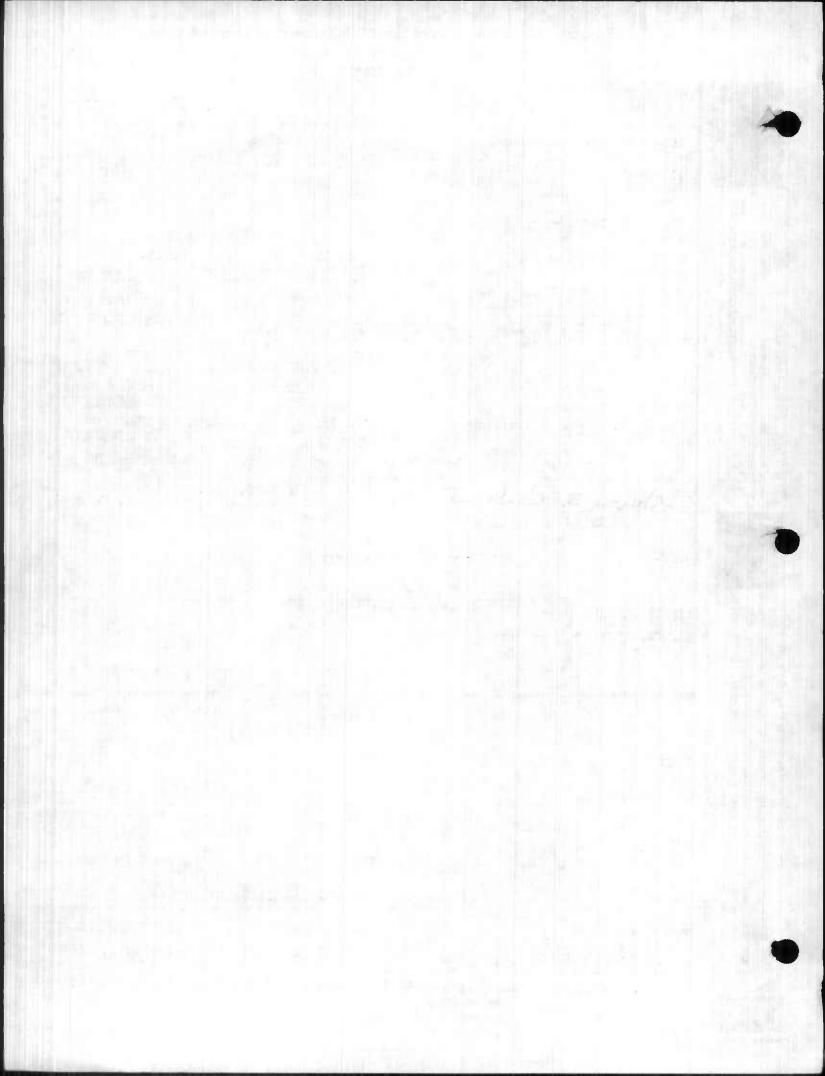
						Ce	ertificat	e of	Death			Reg. No.			
	1. Dece	dent's Name	First, Middle, I	Last)				I-CN			2. Date of De Month	eath Dey	Veer	3. Time	of Death
sician edical	Jud	ith A	nn Berko	witz					3.8		Septer	mber'4,	2000	825	am
miner			not institution, g		um <i>ber)</i>				4b. City, To Bowie		cation of Deat		ty of Death	eorge	s
ral tor	1	Security No.		Sex 1□M 2ŬF	7. Age (In y	70 Yrs.	Months	1 Year Deys		24 Hrs. Min.	8. Date of Bi (Month, D. Jun I.	rth ay, Year) 1, 1930	9. Birth	piace (State ntry)	e or Foreign
uneral Director	Usual R	esidence of	Decedent 10b. County		100	City, Town or L	contion							10d. Inside	Ciby Limite
Director	MD MD			George		Bowie	OCAHON	A							as 2 No
		01 For	nber xhill La				101. Zip					10g Citizen o			
by Funeral	10 3Ö		ed 2 Merried	Armed F	2 No	n U,S. 13.	Wes Deced If Yes, spec				ecify Yes or No Rican, etc.)	BI	aca - Americack, Whita,		
Completed	Flem	(Specientary/Secon	15. Decedent's ify only highest on the property (0-12)	rade completed	) (1-4or 5+)	(Giv-		rk done	pation during mos	st of worki	ing	16b. Kind of Own Ho		idustry	
Com						Home	maker								
To Be	17. Fath		First, Middle, La Marsha						18. Mothe		Mosko	witz	ime)		
	19a. tni		erkowit:									ber, City or Tow , MD 20		o Code)	
b	1		Cremetion 3 5 Other (Special		State	b. Place of Disp cemetery, cre Chesape	emetory or o	ther pla		2.2	Sep 6 2000	20c. Location Belts			
9008	21. Sig	neture of Fui	neral Service Lic	enses	H	2	Rapp 933	Fun Fist	ess of Facili eral Aven	& Cre		Service Spring			
an al er	Immedi	art1. Enter th lock, or hear lete Cause (I e or condition g in death)	ne disease, or contreller. List on Finat		onic O	o (or as a conse	ive Lu	ing			or respiratory (	errest,	1	Approxim Interval B Onset an	Between
icai Examiner	Sequent if any, I cause. Ceuse that init	ntially list coreading to im Enter Under (Disease or lated events g in death) L	nditions, imediate rhying Injury	b		o (or as a conse									
an/Medical		g in death) L	ast	d									1		
by Physician/A	Pert It. C		cent conditions			_				t.		tobacco usa d X Yes 2□ No			of death?
by	-	steopo	orosis							٣		s an autopsy formed?	81	Vere autops vailable prid	or to
Completed				1,11,2							10	lYes 2 No	of	ompletion of death?	of cause
Se Com			red to medical						26. Place	e of Deeth	n (Check only	one)			
		miner? Yes 2. ☑	No	Hospital:	Inpatient 2	2 ☐ ER/Outpatio	ent 3 DC	OA O	ther: 4 N	ursing Ho	me 5 ☐ Res	sidenca 8 🗆 C	ther (Speci	ity)	
To 8	10	27. Manner of Death  1 Netural 5 Pending (Month, Day Year)  28b. Time of Injury Work  1 Accident investigation									28d. Describe	how injury occ	urred		
Certification:		Suicide Homicide	6 Could not determine	209. Plac	e of Injury - A ding, etc. (Spi	At home, farm, s ecify)	treet, factor	y, office				(Street end Nul own, State)	nber or Rui	ral Route N	umber,
Medical Cert			1☐Certifying ( 2☐ Medical Ex		e best of my basis of exam nner steted.	knowledge, dea ninetion end/or i	th occurred nvestigetion	at the t	lime, date ar opinion, dee	nd place, a	and due to the ed at the time	e cause(s) and e, date and piac	manner as	stated. to the caus	e(s)
v V	29b. Sig	mature and	title of certifier	rul	MI	//		c. Licen	se number	14		29d. Date sign	1	Day, Year	
			Meade I					, L	aurel	, MD	20708			- 1	
State	31. Date	e fitted (Mont	th, Day, Year)	32.	Registrar's Si	gneture	1	1	,						



State of Maryland / Department of Health and Mental Hygiene 00 294,97

					Ce	rtificate	of i	Death			Reg. No.		
	1. Decedent'a Nam	ne (First, Middle, L	ast)							2. Data of De	ath		3. Tima of Death
Physician	Mal	nel Eng	lish	Bergmann						Sept.	2, Day 200	O Year	11:10 AM
/Medical	-	(If not institution, gi					1	4b. City, To	wn, or Lo	cation of Death			
Examiner		ncaster M						Rocky	ville	2	Mont	gomer	у
	5. Social Security I		Sex	7. Age (In yrs. la	st birthdev)	if Under	1 Year	If Undar	24 Hrs.	8. Data of Bir	lh	9 Birthi	placa (State or Foreign
Funeral Director	217-46-		1□M 21xF	99		Months	Deys	Hours	Min.	8. Data of Bir (Month, De Aug 19	y, Year)	Wash	ington, DC
Director	Usual Residenca			9:	7					nug 17	, 2702	Wabii	ingcon, 20
illed within 72 hours sitel death with the maryland ther than "natural", or flems 23s or 28s-f show but, the Madical Examiner must be notified at a Completed by Funeral Director	10a. State	10b. County		10c. City,	Town or Lo	ocation							10d. Inside City Limits
A P	\m	Wh		CL	evy C	haga							1⊠ Yas 2□ No
ect out	MD 10e. Street and Nu	Montgo	mery	CI	levy C	10f. Zip	Code				10g. Citizen of	Milhet Cou	-t2
- A													rittyr
23a	8051 Gl	endale Ro					208				U.S.A		
ral', or flows 23s or 25s-f show Examiner must be notified at i by Funeral Director	11. Marital Stelus		12. Wes Dec	edent Ever in U,S orcas?	3. 13.	Was Decede If Yes, speci	ent of H ify Cubi	lispenic Ori an, Mexicar	igin? (Spi n, Puarto	ecity Yes or No Rican, etc.)	- 14. Ra	ca - Ameri ick, Whita,	can Indian, , atc.
SE II	1 Nevar Man	ried 2 Married	1 Tes	2⊠ No		1□ Yas 2		Specify:			Specia	fv: TTL.	2 An
edical Examination		4 Divorced	Year or D				X	Openny.			Specif	y: Wh:	ıte
event, the Medical in Be Completed	(500	15. Decedent's E			16a. Dece	dent's Usuel	Occup	ation	et of work	ina	16b. Kind of B	lusiness/Ir	ndustry
	Elemantery/Sec		College (	1-4or 5+)	life.	kind of work DO NOT use	e retired	d)	i oi work	mg			
E O	1.	_ ' ' '	00090 (		Home	maker					Own H	ome	
Be	17. Father's Neme	(First, Middle, Las	t)					18. Moth	er's Name	e (First, Middle	Meiden Sumer	me)	
To B	Jehu	Lambkir	1					M	ary	Elizab	eth Mc	Conau	ighe
-	19a Informant's N	lame/Reletionship		1000	19b. Meili	na Address	(Street	and Numb	er or Run	al Route Numb	er, City or Town	. Stete. Zi	p Code)
9		B. Blake		ghter)		Eucli					n, MD 2		
or other treumatic	20e. Method of Dis		(Dau	-		osition (Nam		1110	10.	Dete	20c. Location		own State
5		Cramation 3 €	Ramoval from	Stala ce	metery, cre	metory or of	her plei						
	4 Donation	5 Other (Spec	ify)	Roc	k Cre	ek Cer	nete	ery	10	19/06	Washing	gton,	DC
eny injury or	21. Signature of F	uneral Sarvice Lice	ensee	1		2. Name and				IC TNC			
<b>S B</b>	1	50 \ B	Kine	Russ		OSEPH 130 W:				NS, INC	Jaching	ton.	DC 20016
	23a. Part1. Entar	modisease, or cor	nolications that o	aused the death.								,	Approximata
	shock, or he	art failure. List only	y one cause on e	ech line.									Intarval Batween Onset and Death
cian dical	Immediate Cause	/Final											
niner	diseasa or condition	on	a. Ce	rebrovas	scular	Acci	den	t				1.	19 days
	rasuning in douting			Dua to (or	as a conse	quence of):						1	
i e			b									1	
Examiner	Sequentially list or	onditions,	0.	Dua to (or	as a conse	quance of):							
Nor use as the bunal-transit clan/Medical Examir	Sequentially list or if eny, leading to li cause. Enter Und Ceuse (Diseese or that initiated event	mmadiata lerlying											
edicai	that initiated event	ts l set	C	Due to (or	as a consec	quence of):						1	
P 0	rasulting in death)	Last										- 1	
es Z			d									1	
Physician/	Part If Other elani	ificant conditions	contribution to d	eath but not recui	tion in the u	oderhina ca	uea ai	on in Part	4	23h Did	tobacco use co	natribute :	to the cause of death?
Syc Syc	Part II. Other signi	Incarit Conditions	contributing to a	eath out not lesu	ung m ma c	indenying ce	ausa yii	ron in Fart					
detached for Physicia										'''	Yes 2 No	30 -10	obably 4 Unknow
2 2										04-144		7.4h W	Vara autopsy findings
Completed										perfe	an autopsy ormed?	a	vailable prior to omplation of cause
pie Z										1000		o	death?
Com										10	Yes 2K No	1	□Yas 2□No
	25. Was case refe	erred to medical			170	-		26 Piac	e of Deat	h (Check only	nne)		
o Be	examiner?		Hospital:	Inpatiant 2 E	R/Outpatie	nt 3 DO	A Oth					har /Saac	Hospice
ß	27. Manner of Dea				28b. Time o				ursing no		how injury occu		ny) Hospice
Certification:	1 Netural	5 Panding		of Injury th, Day Year)	Injury	М	Bc. Injui	rk?  Yas 2□	l No				
the cat	2 Accident 3 Suicide	invastigetion	he	44.1				103 2	140	OOS Loosting	Chanat and Muse	haras Du	nel Doute Mumber
completely filled in by the fune Medical Certification	4 Homicide	determine	288. PIECE	of Injury - At hor ing, etc. (Specify,	ne, farm, st	reet, factory	, office			City or To	wn, Stete)	iber or Mu	rel Route Number,
3 3													
cal	29e. Certifier (Check only	1⊠ Certifying P 2 Medical Exa		best of my know									
completely filled in by the tune  Medical Certification	one)			ner stated.	and of It	- congenon,		,		a. the time,	Tare and proof	,	
E com	29b. Signature and	d title of qurtifier	10	1		29c	. Licens	se number			29d. Date sign	ed (Month	, Day, Year)
D	D11/	DITA	X	200	n 14	Tr	מחמ	37620			Septem	ber 2	2, 2000
	30 North	VUYY	1-4	all the	2201/77	74.1		,, 520					
	30. Name and add		TO COMPIETE CAUS	sey Hous	238) (Type,	01 Mar-	2000	tor h	/+11	Rd R	ockwill.	, MD	20855
		Godec, M				or Hui	icas	LEI I	2.4. de de	214.9 111	JUN ALL	-, 110	20000
State	31. Date filed (Mos		200	Registrer's Signat	ura	1							
egistrar	5	EP 05 2	JUU JO	nach	1.	Spa	Ks						

**DHMH 16 Rev 6/95** 



State of Maryland / Department of Health and Mental Hygiene

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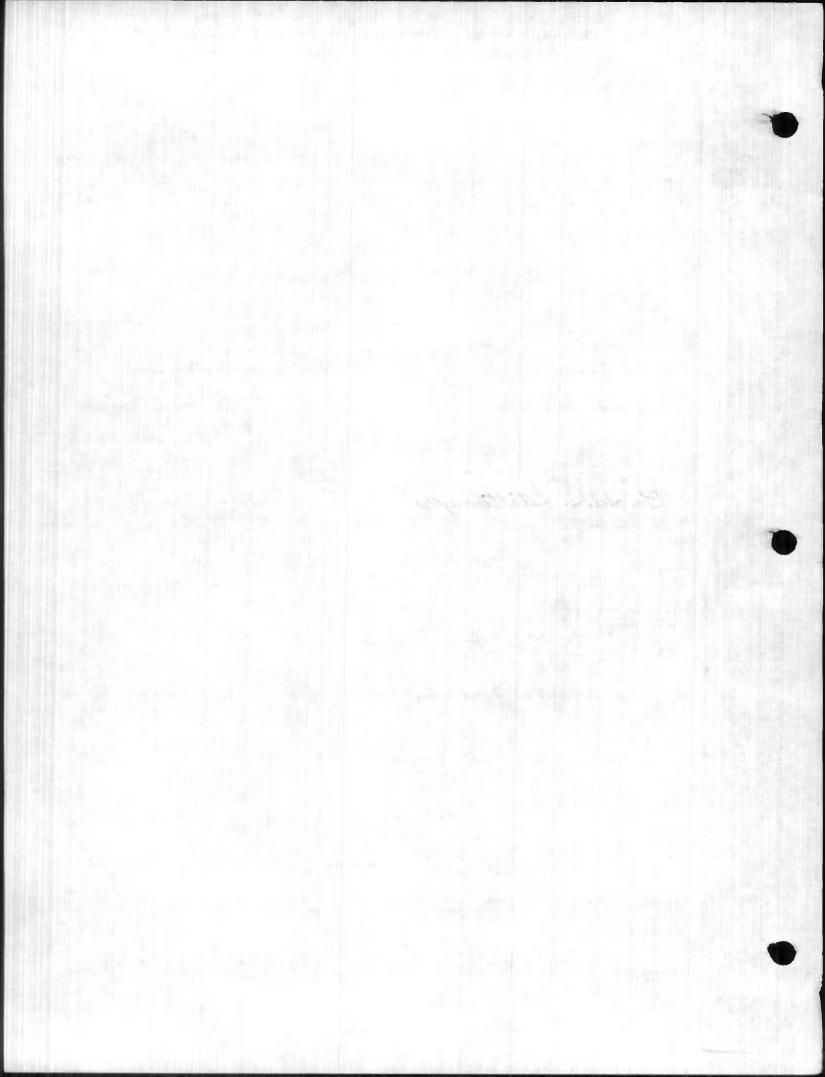
29698

					Ce	ertifica	te of	Death			Reg. No.		2770
	1. Decedent's Nan	me (First, Middle, La	ist)							2. Data of De			3. Time of Death
Physician	Henry Be	ergman								Month Septem	ber 2, 2	Year 2000	12:20 PM
/Medical Examiner		(If not institution, gh	e street and nu	ım <i>ber)</i>				4b. City, To	own, or Lo	ocation of Deati			12120 111
Examiner		n Hospita						Rot	theso	10	Mont	gome	<b>*</b> ***
	5. Social Security		Sex	7. Aga (In v	rs. last birthda	v) If Unde	er 1 Yaar		24 Hrs.	8. Date of Bir (Month, Da			
Funeral Director	060-10-		1⊠M 2□ F		86 Yrs.	Months	Days	Hours	Min.	Oct. 3	ly, Year)		place (State or Foreign ptry) W York
Director	Usual Residence							1		0000	, 1)13	1,6	WIOIK
E S IN	10a. Sfate	10b. County		10c.	City, Town or	Location						1	Od. Inside City Limits
the so	MD	Montgo	merv		Garret	Park							1⊠Yes 2□No
be notified	10e. Street and Nu				-		p Code			I	10g. Citizen of V	What Coun	ntry?
D Be		bemarle A	17.0				2089	16			U.S.		
iner must be notified at iner must be notified at Funeral Director		Demarie A		edent Evar i	olic is	Was Door			ining (Cn	poity Voc or No		a - Amaric	an Indian
Dec un	11. Marital Status		Armed F	orcas?	10,5.	If Yes, spe	ecify Cub	en, Maxica	n, Puerto	ecify Yes or No Rican, afc.)	Blad	ck, White,	
by F		rried 2 Married	If Yes, G		WWII	1 Yes	2 No	Specify			Specify	/: Ta	Mhite
	3 gg 11100Wed		Year or E	Jales:		and and to the		nation			10h Kind of B		
ete ete	(Spe	15. Decedent's E ecify only highest gr	ducation ade com <i>pleted)</i>	)	(Gir	edent's Usi	ork done	during mos	st of work	king	16b. Kind of B	USHIOSS/HR	oustry
Completed	Elementary/Sec	condary (0-12)		(1-4or 5+)		b Car			ar Ac	ivocate	Ноз	1+h 1	Research
ပိ		det	5+		near	ch oar					, Maiden Suman		Research
To Be		(First, Middle, Las	)								, walden Suman	10)	
0	David H.	. Bergman						Ma	ary A	Aronoff			
	19a. Informant's h	Neme/Reletionship	(Type, Print)		19b. Ma	iling Addres	ss (Street	and Numb	er or Rui	ral Route Numb	er, City or Town,	State, Zip	Code)
	Ellen P.	. Friedma	n/ Daug	hter	84 C	onstit	tutio	on Way	y, Co	onvent :	Station,	NJ (	07960
5	20a. Method of Dis				b. Placa of Dis	position (Na	ame of other pla	ce)	1	Date	20c. Location -	City or To	own, State
h		2 ☐ Cremation 3 ☐ 5 ☐ Other (Speci		State	Judean					ep. 5,	Olney,	MD	
量。		uneral Service Lice				22. Name a			- 1		,		
18	DA.	110	May	**		Danzar	isky-	-Goldl	perg	Memoria	al Chape	1s,	Inc.
	Con	the disease, or con	ruse	um							ville, M	ш 208	Approximate
ician dical niner	Immediate Cause diseasa or conditi resulting in deeth)	(Finat	0114 04330 011	1monar	y Edem	a							Onset and Death  2 Days
<u> </u>	THE RESERVE		Ts		Cardi								
ts the burial-transit	Convention to tiet o		b		o (or as a cons								
Ex	Sequentially list of if any, feading to it	immediate		500 (	0 (01 45 4 5516	equolico o	,						
Ca	causa. Enter Und Cause (Disease of that initiated even	or injury	C	Due t	o (or as a cons	paulance of	١٠					-	
8	resulting in death)	) Last		D08 (	o (or as a cons	aquerice or,	,						
ZMe as			d										
Physician										1			
ysi	Part ff. Other algn	ificant conditions	contributing to d	death but not	resulting in the	underlying	cause gi	ven in Part	1.				o the causa of death?
	Der	mentia								10	Yas 2 No	3∐ Pro	bably 41 Unknown
2 2										040 18/00		24h W	ere autopsy findings
should											s an autopsy ormed?	av	railable prior to
mple												of	deeth?
Completed										10	Yes 21 No	11	☐ Yes 2☐ No
Be C	25. Was case refe	erred to medical						26. Plac	e of Dea	th (Check only	one)		
- 0	examiner?	■ No	Hospitel:	Unpatient :	2 ER/Outpat	ient 3 🗆 D	OA Ot	her: 4 N	lursina H	oma 5□Res	idence 6 Ott	ner (Speci	fv)
755	27. Menner of Dea	ath	28a. Dete	of Injury	28b. Time	of	28c. Inju				how injury occur		
fune	1 ⊠Natural 2 ☐ Accident	5 Pending invasfigation		nth, Dey Yea	r) Injun	м		Yas 2	) No				
fice the	3 Suicide	6 Could not I		e of Injury - A	At home, farm,	street, facto	ry, office			28f. Location	(Street and Numi	ber or Run	al Route Number,
led in by the funera Certification:	4 Homicide	ooton moo	build	ding, etc. (Sp	ecify)					City or To	wn, State)		
completely filled in by the fune.  Medical Certification	29a. Certifier (Check only	1⊠ Certifying Pi 2□ Medical Exa	miner: On the b	pasis of exam									
To the Funeral Director: completely filled in by the Medical Certifical	one)	d bidle of a still of	and mer	nner stated.			On Linns	sa number			29d. Data signe	nd /Month	Day Veer
8	29b. Signature an	A CHINES TO BILL DI	w	D.		2							
5		grun					וצע	7891			septen	wer .	2, 2000
	30. Nama and add	dress of person who	completed cau	ise of death (	(Item 23e) (Typ	e, Print)		- 1 - 1 - 1	1.00				
	A. Rasva	anshi, MD	121 Co	ngress	sional :	Lane,	# 40	09, Re	ockv	ille, M	D 20852		
State	31. Date filed (Mo	onth, Day, Year)		Registrar's S	ignature /	-	9						
Registrar	9	SEP 062	UUU.	Cycare	D.	60	out.	2					

DHMH 16 Rav 6/95

BERGMAN

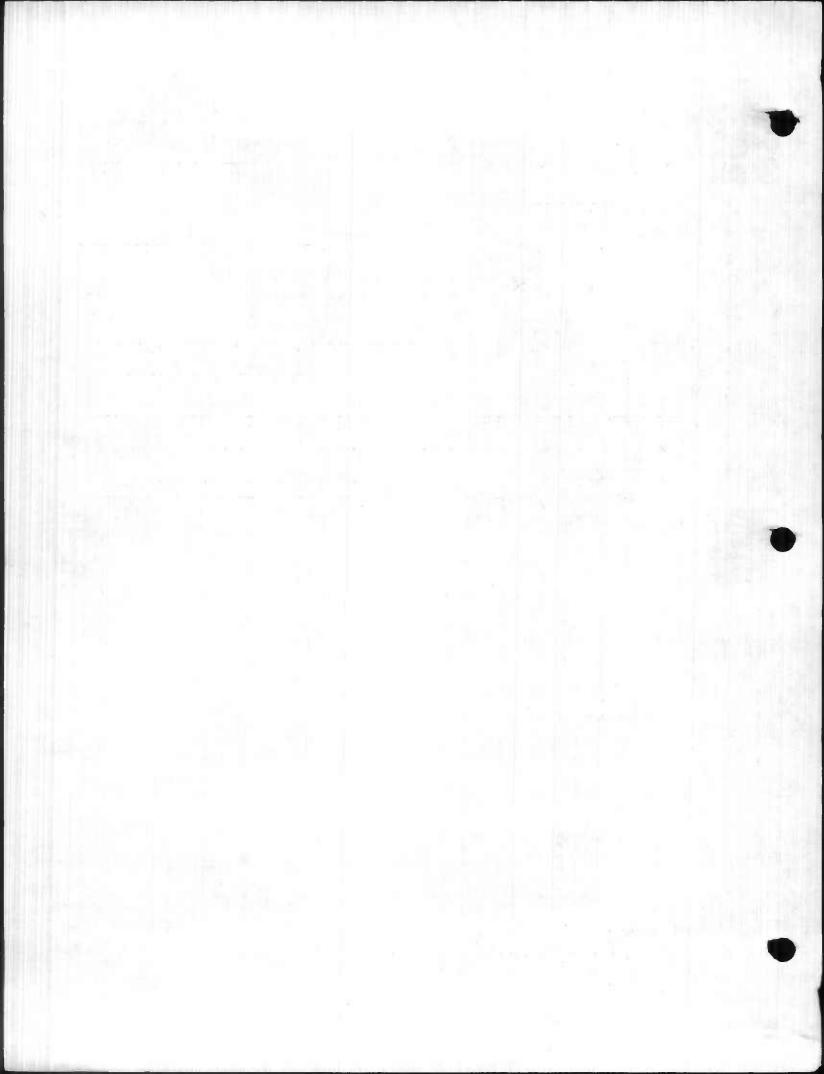
HEN RY



State of Maryland / Department of Health and Mental Hygiene

		otate of marylan		ificate of			ng. No.	29499
Ohusisian	1. Decedent's Name (First, Middle, Las					2. Date of Deal Month	h	3. Time of Death
Physician /Medical	NORMAN LE		120-			AUG. 3	0, 2000	10:58 AM
Examiner	4a Facility Name (If not institution, give		an rmar		4b. City, Town, or L		4c. County of	
Funeral	CARROLL COUNTY  5. Social Security Number 6. Se		SPITAL last birthday)	If Under 1 Year	WESTMIN  If Under 24 Hrs.	8 Date of Birth	CARRO	D. Birthplace (State or Foreign
Funeral Director		XM 2□F 63	Yrs.	Months Days	Hours Min.	O Chonth. Day.	,T936	GEXAS
20	Usual Residence of Decedent	10c Cit	y, Town or Loca	ation				10d. Inside City Limits
f sho	MD. 10b. County FREDER I	CK	y, roun or coo	NEW MAR	RKET			1 ☐ Yes 2 ☑ No
The motific	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	at Country?
O ther death with the Maryla r thams 23s or 25s-f show black must be notified at Funeral Director	5605 BOBOLINK PL	ACE		2:	1774		UNITE	D STATES
r des	11. Marital Stalus	12. Was Decedent Ever in U Armed Forces? 1 0	s. 13. w	as Decedent of H Yes, specify Cubi	tispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, Whita, etc.
	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No 19 If Yes, Give Year or Dates: 19	33-	TYes 2 No	Specity:		Specify:	WHITE
	15. Decedent's Edi	ucation	16a Decede	nt's Usual Occup	pation		16b. Kind of Busi	
1 21215-0 ed within 72 ho typiene. typiene. t, the Medical.	(Specify only highest grad	de completed)  College (1-4or 5+)			during most of work d)		Danie	
CA DEPT N	12	3	VICE	PRESIDE	T - MANA		BANKI	
land lid be fill bed out cever o Be	17. Father's Name (First, Middle, Last) MELTON - BASS	5			18. Mother's Nem ELIZABI	ETH ANNE	NESMIT	
Maryland 42 should be file th and Mental Hy 7 is marked event traumatic event To Be (	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailing	Address (Street	and Number or Rur	al Route Number	, City or Town, S	tate, Zip Code)
C-SNL	ELIZABETH ANNE BA	ASS, WIFE	5605	BOBOLINI	K PLACE, NI	EW MARKE	T, MD. 2	21774
Baltimore, somit. Peges 1 a Department of Hea montant: If Hem my injury or othe ance.	20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from State D /	lace of Disposi emetery, creme DV 1 AUIN	tion (Name of story or other ple CEMETER	ce)	9/2/00		ity or Town, State .LE, MD.
L Pag	4 □ Donetion 5 □ Other (Specify	)						LE, MU.
Balt permit. Departs Imports any inje	21. Signature of Funeral Service Licens	Il Backer			ss of Facility BARBER			
y	23a. Pert1. Enter the disease for comp shock, or heert failure. List only of	lications that caused the deet			5038, LA			Approximate
Physician	shock, or heert failure. List only o	one cause on each line.						Interval Between Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition	ALZHEIME	R'S					5 YRS
	resulting in death)		r as e consequ	ence of):	7.1			1
d ansit	Convention list conditions	b. ASCVD	r as a consequ	ence off:				15 YRS.
O, and an an an an an an an an an an an an an	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events	500 10 (0	as a consequ	once ory.				t
68760, fifcate be assecuted aphysician and as the bunial-transit edical Examiner	that Initiated events resulting in death) Last	C. Due to (o	r as a conseque	ence of):				
		d						
The law requires that the death cent are has been signed by the attending page 2 should be detached for use.  Completed by Physician/M	Part II. Other significant conditions co	atributing to death but not rec	ulting In the unc	larhing cause di	en in Part I	23h Did to	haces use cont	ribute to the cause of death?
Cords, P.O. v requires that the de been signed by the s should be deteched leted by Physic	Ofil 6	- h	and girl the circ	Jony ing Cadoo gi	7011 W F 011 1.			B Probably 4 Unknown
es thu	- Curac I							
lecords, P.O law requires that the as been signed by th 2 should be detach npleted by Phys						24a. Was a perform		24b. Were autopsy findings available prior to completion of cause
The law the has begge 2 s							as all No	of death?
of Vital Records, Physician: The law requires to riblis cartificate has been signe and director, page 2 should be n: To Be Completed by	25. Was case referred to medical				26. Place of Deel	1 Ye		1 Yes 2 No
Of Vita Physician: this certific ral director,	examiner?	Hospitel:	ER/Outpatient	3X DOA Ott	or.	ome 5 Reside		(Specify)
DIVISION Of or Attanding Physister death. Director: After this in by the funeral di ertification: To	27. Manner of Deeth 1 X Natural 5 ☐ Pending	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju	y at	28d. Describe he		
OIVISION or Attending after death. Director: After in by the fune ertification	2 Accident Investigation 3 Suicide 6 Could not be	COn Class of Injury As h	(		Yes 2 □ No	20f Losstion /O	root and Number	or Rural Route Number,
DIVISION ( DIVISION (	4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	y)	st, ractory, onice		City or Town	n, State)	or rigital rigidal values,
Hospital or 24 hours after Funeral Directions staly filled in	29a. Certifier 1 Certifying Phy	sician: To the best of my kno	wledge, deeth o	occurred at the tie	me, date end place,	and due to the c	ause(s) and man	ner as stated.
Division  To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completaly filled in by the funeral Medical Certification	one)	iner: On the basis of examina and manner stated.	tion and/or inve					
	29b. Signature and title of certifier	1111		29c. Licens				(Month, Day, Year)
15+1	() must	www	00-107	D254	43	A	UG. 30	, 2000
	30. Name and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person and address of person and address of person and address of person and address of person and address of person and address of person address of person and address of person add	688 DOO			MINSTER	MD 2	1157	
State	31. Date filed (Month, Dey, Year)	32. Registrar's Signa				11110 2	1137	
Registrar	SEP 0 5 20	00 Senera	Ø.	porks	/			

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 00 29500

						Ce	rtificati	e of	Death			Reg. No.		
		1. Decedent's Nama (First,	Middla, La	st)					DE W		2. Data of De		Wasa	3. Tima of Death
	Physician	MAURICE	FA	RVER	BAILE	5.					Month 9	Day 3	Year 2000	2-05 PM
F	/Medical Examiner	4a Facility Name (If not ins							4b. City, To	own, or Lo	ocation of Death			
~	LAGITITIE	Carroll Cou	inty (	General	Hospita	1			West	mins	ster	(	Carro	11
1	Funeral	5. Social Security Number	6. 5		. Age (In yrs.		If Undar		If Undar		8. Data of Bir (Month, De	th .	9. Birthp	lace (Steta or Foreign
-81	Director	213-18-8362	1	☑M 2□F	81	Yrs.	Months	Days	Hours	Min.	Dec. 1	y, Year)	Coun	vland
		Usual Residence of Deceda	int			37					200. 2.	,		) = 4.1
	N S W	10a. State 10b. C	ounty		10c. City	, Town or L	ocation						1	0d. Inside City Limits
	28a-fat notified rector	Maryland	Ca	rroll		W	estmi	nste	er					1 ☐ Yas 2 ☑ No
	or 28e-f.s a notifie Directo	10e. Street and Number					10f. Zip	Code			-0.5	10g. Citizen of	What Coun	itry?
	A Paris	1638 016	Tane	eytown R	d.		Par		2115	58		U.	S.A.	
	ma 2 ma 2	11. Marital Status		12. Was Deced	dent Ever in U,	S. 13.	Was Deced	lant of H	lispanic Or	igin? (Sp	ecify Yas or No Rican, atc.)	- 14. Rad	e - Amaric	
0	F 44 F	1 Never Married 2	Married	Armed For	2 No No						Hican, atc.)		ck, White,	
020	by Er.	3 □ Widowed 4 □ Div	orced	If Yes, Give Year or Da			1 Yes	2 No	Specify			Specif	y: Whi	.te
9	ted call	15. De	edent's E	ducation		16a. Dece	dent's Usua	al Occup	etion			16b. Kind of B	usiness/Inc	dustry
218	ed within 72 haygiens.  We then "natur  It, the Medical.  Completed	(Specify only Elementary/Secondary (C	1	College (1-	Aor 54)	lifa.	kind of wo	rk done	<i>auring</i> mos d)	st or work	ing			
21	the state	Libinorial y/Cacordary (C	12/	Compye (1-	401 347		mecha	nic				auto	omobi.	1e
P	De lile d othe went,	17. Fathar's Name (First, M	iddle, Last	)			-55	13	18. Moth	er's Nam	e (First, Middle	Maiden Surnar	na)	
lar	Perting of the perturbation of the pertur	Maurice H. H	Baile							Ethe	el Farv	er		
Maryland 21215-0020	No.	19a. Informant's Name/Rel	atlonship (	Type, Print)		19b. Malli	ing Address	(Street	end Numb	er or Rur	al Route Numb	er, City or Town	, State, Zip	Code)
2	27 to 27	Virginia M. I	Baile	/ wife		1638	01d	Tane	ytow	n Rd	. We	stminst	er, M	D 21158
9	T T T	20a. Method of Disposition			20b. P	lace of Disponentery, cre	osition (Ner	ne of	1		Date	20c. Location	- City or To	own, State
altimore,	S H S	1 Burial 2 Cremi								. 9	/5/00	Hampste	ad. M	1D
重	influence of	21. Signature of Fugeral Se			0							•	· · · · · · · · · · · · · · · · · · ·	
Ba	Deplement	1 atha	. (	(X/2	1000 n							uneral		
	STATE CON	arriar	ne !	V. Yun	4500							lsor, MD	21//	
4		23a. Part1. Enter the disea shock, or heart failure	. List only	one cause on ea	ich line.	n. Do not en	ter the mod	e or ayır	ng, such as	cardiac	or respiratory a	rrest,	1	Approximata Interval Between Onset and Death
	Physician	In-market Course (First			λ.	- A	A. 1			77		, ,		Ondet and Death
	/Medical Examiner	Immediate Cause (Final disaasa or condition resulting in death)		8.	HCV	16-1	1700	AR I	SIAZ	11	VFARCT	202		
		1000king in county			Due to (o	ras a conse	quence of):							
	in sit			b									ì	
	cate be executed physician and sthe burial-transit	Sequentially list conditions			Due to (o	r as a conse	quence of):							
68760,		Sequentially list conditions if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury		c										
87	certificate be ding physicla use as the but	that initiated events rasulting in death) Last		0.	Due to (or	as a conse	quenca of):							
9 ×	E Die M		·	4										
Вох	deeth ca a attend ad for us	THE ROLL		0	MEL.	1 700							1	
	The law requires that the deeth certain has been signed by the attending page 2 should be detached for use Completed by Physician/N	Part II. Other significant co	nditions o	ontributing to dea	ath but not resi	ulting in the u	underlying c	ause giv	en in Part	1.	23b. Did	tobacco uss co	ontribute to	the cause of death?
P.0	ed by detact	CORO	NAN	Y ART	RRY	ALCE	A (3				10	Yas 2□ No	3 Pro	bably 4 Utilknown
Ś	b d												1	
of Vital Records,	equires ben sign nould be	MYE	200	ISPLAS	510	SUN	DRO	MIS			24a. Was	an autopsy ormed?	av	ara autopsy findings allable prior to
90	2 sh												of	mpletion of cause death?
Œ	certificata has rector, page 2 Be Comp	Elitaria al	C.	0-8-	7						10	Yes 2 No	1[	Yes 25 No
a	entifica ector, p	25. Was case referred to m	edical						26. Plac	e of Dea	th (Check only	one)		
>	Physician: this certific ral director, TO Be	examiner?		Hospital:	patient 2	ER/Outpatie	nt 3 DO	Oth	ner: 4 🗆 N	ursing He	ome 5 Resi	dence 6 □Ot	her (Specif	50)
0	E E E	27. Manner of Death		28a. Date of		28b. Time o		Bc. Injui				how Injury occu		,,
0	tto fun	1 Matural 5 ☐ F	anding nvestigatio		i, Dey Year)	Injury	М		Yes 2	] No				
Division	Attending r death. ector: After by the fune lfication	3 ☐ Suicide 6 ☐ C	Could not b	200. Fiace	of injury - At he	ome, farm, st	reet, factory	, office			28f. Location (	Street and Num	ber or Rura	al Route Number,
á	tal or Attending P as after death. al Director: After t led in by the funera Certification:	4 Homicide		buildin	g, etc. (Specify	y)					City or To	wn, Stete)		
	Hospital 24 hours Funeral tely filled	29a. Certifier 10 Ce	rtifying Pt	ysician: To the t	pest of my kno	wiedge, deal	h occurred	at the tir	me, date a	nd place,	and due to the	cause(s) and m	anner as s	tated.
				niner; On the bar and mann	sls of examina									
	Within To the comple	29b. Signature and title of o	ertifier				290	. Licens	se number			29d. Date sign	ed (Month,	Day, Year)
	->-0	1 1	1.1	16	jus			039	502	M	A	9/3	1200	0
		30. Name and address of p	arena who	completed cause	of death (tte-	23a) /Time	Print)					-/	-	
		SUED . S.	TO S.	AN M				/ M	No.	V/2	WELTH	MICTOR	Mi	21157
	Charles	31. Date filed (Month, Day,			gistrar's Signa		-,100		9/41	7	וון וכט איי	VIIOIC		2114
	State Registrar		052		Jenera		1	pack	11					
	, regional	OLI	U U C	000			14	MAR	2					

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